

Old Mill Chiropractic Pediatric Intake Form

Initial Exam Date _____

Patient Information

Child's Full Name _____ Nickname _____ DOB _____
First MI Last

Address _____ City _____ State _____ Zip _____

SS # _____ Sex: ☐ Male ☐ Female Parent/ Guardian's Name _____

Race _____ Primary Language Spoken _____ Ethnicity _____ Age _____

Contact Information

Home Phone _____ Cell Phone _____ (Parent's) Work Phone _____ Ext. _____

I prefer to receive calls at: ☐ Home ☐ Work ☐ Cell

Emergency Contact _____ Relationship _____ Contact Phone _____

How did you hear about us? _____

Payment and Insurance Information

Person Responsible for Payment _____ Date of Birth _____ Phone _____

Medical History

Describe the reason for your child's visit _____

When did their symptoms begin? _____ How did their symptoms begin? _____

History of Treatment

Primary Care Physician _____ Facility _____ Phone _____

Have they seen a Chiropractor before? ☐ Yes ☐ No If yes, when was their last visit? _____

Have they seen another doctor for these symptoms? If yes, who? _____

List all prescription and non-prescription medications, as well as supplements they take. Include associated conditions.

Consent for Treatment

Assignment & Release- By signing below, I authorize Old Mill Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Old Mill Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or the amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations. By signing below, I give my consent for examination and the performance of any tests, treatments or procedures needed. If the patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Patient/Guardian Signature _____ Date _____

Old Mill Chiropractic, LLC
711 East Main Street, Suite L2
Lexington, South Carolina 29072

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient name), hereby acknowledge that I was informed of the Privacy Practices Policy Statement ("Privacy Notice to Patients") at oldmillchiropractic.com. I understand that any questions or concerns that I may have about this notice can be addressed to Dr. Nazarenko or the Office Manager at any time.

Patient Signature or Legal Representative

Date

Relationship to Patient

For Office Staff Only: _____ Initial if patient declined

Notice of Privacy Practices given to the individual on _____ (Date)

Reason for Decline: _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must have been made.

Face to face presentation(s) _____

Telephone contact(s) _____

Other _____

Dr. Eric Nazarenko, DC
Old Mill Chiropractic, LLC
711 East Main Street, Suite L2
Lexington, SC 29072
803-808-0711

CONSENT FOR TEXT AND EMAIL MESSAGES

I hereby give my consent for Old Mill Chiropractic, LLC to send text message reminders to my mobile telephone (as per the number listed below). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to schedule an appointment. I understand that appointment cancellations should be done by phone.

I additionally hereby consent for Old Mill Chiropractic, LLC to send me email notifications and newsletters to the email address listed below.

I understand that any correspondence regarding my care will continue to be made via direct contact on the phone or in person.

I understand that I have the right to change my mind at any time. I will let the office know in person, writing or by phone if I wish to have this service stopped.

Patient Name(s): _____ DOB: _____

Cell Phone Number: _____

Email Address: _____

Signature: _____ Date: _____

Please be sure to let the office know of any changes.