FAMILY CHIROPRACTIC

Rogersville at Riverscape
Aric D. Butler D.C. Quentin G. Hendrix D.C.
Rogersville: 256-247-4000 / 256-229-6992 Fax: 844-525-9890

Child Case History

Date: ___/___/____

Welcome to Family Chiropractic! In order for us to best meet your healthcare needs, please fill out the following form thoroughly.

Which Doctor will you be seeing today?
☐Aric D. Butler D.C. ☐Quentin G. Hendrix D.C.

Patient's Name: First____________________ MI______ Last________________________
Address: ____
DOB: ___/___/____ SS#: ______________ ☐Male ☐Female
Height: ____________ Weight: ______________
Home # __________________ Cell # __________________(wireless carrier)______________
Email: ______________________________________

Would you like appointment reminders? Yes _____ No______
If yes (check only one) Email: ________ or Text: _________

Mother's Name: First____________________ MI______ Last________________________
Address: ____
Father's Name: First____________________ MI ______ Last________________________
Address____

Insurance Information

Name on Card____
Primary's DOB: ___/___/____ Primary's SS#:________________________
Emergency Contact: Name______________________ Phone #: ______________________
Relationship to Patient ____________________
Primary Care Physician: ____________________ City/State: ______________________

Child Health History

Present complaint of child:____
____
History of childhood ailments, medical, or surgical treatment:______________________
____
Any childhood accident, falls, or fracture:____
____
Present Medications: ____
Please give a brief account of child's birth (Natural, C-section): ______________________
____
Was forceps or vacuum used? ____
Please give accounts of child's normal diet:____
____
Does your child have any special interest such as hobbies, sports, etc? ________________
____

Authorization

I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

X____

Signature of Patient (or parent of minor) Date

Rogersville Family Chiropractic

Aric D. Butler, D.C.
17520 Hwy 72, P.O. Box 219
Rogersville, AL 35652
256-247-4000

CONTACT INFORMATION SHEET

Patient Name: ______________________________
Social Security Number: ______________________________

Any physician, staff, employee, or representative of Rogersville Family Chiropractic has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

□ I do not want anyone to have access to my protected health information unless I provide explicit authorization

If unable to reach me:
- □ You may leave a detailed message.
- □ Please leave a message asking me to return your call.
- □ Do NOT leave a message.

IF ANY INFORMATION ON THIS FORM CHANGES, IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY ROGERSVILLE FAMILY CHIROPRACTIC IMMEDIATELY.

Signature Name of Patient ______________________________ Date ______________

Printed Name of Parent/Patient's Representative (If Applicable) ______________________________

Signature of Parent/Patient's Representative (If Applicable) ______________________________

Employee Witness ______________________________