Dr. Larain M. Valenti

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CONSENT TO TREAT MINOR

This consent gives Dr. Valenti permission to treat_____.
He / She will receive an examination and recommendation for treatment. This may include the following: adjustments, therapeutic modalities, stretching, manual therapy, and at home exercises. If Dr. Valenti believes x-rays are medically necessary she will make a recommendation to have them taken at an outside facility.

_____
Print Name of Parent/Guardian

_____
Signature of Parent/Guardian

_____
Date

PEDIATRIC HEALTH HISTORY
WELCOME TO OUR FAMILY!

Date_____

1- Patient Information

Patient Name _____
Patient Address_____
Patient Phone # _____
Patient DOB: _____ Referred by: _____
Name of Pervious Chiropractors: _____ Date of Last Visit: _____
How long was child receiving Chiropractic adjustments? _____
Who should be contacted in case of emergency? _____
Does your child participate in any sports/activities? If so please list:
_____

2- Parent/Guardian Information

Parent/Guardian Name: _____ DOB: _____
Address (if not same as patient):_____
Home Phone #: _____ Cell Phone #:_____
Best time/place to be reached: _____

3- Patient Condition

Child's reason for coming in? _____
What accidents has child had (i.e. Bicycle, car, sports, slips/falls) at school or at home (include dates)?
_____
_____
Was child ever knocked unconscious? _____
What fractures, broken bones, or dislocations has child had? (Include dates)
_____
_____

4- Prenatal History(please fill out to the best of your ability)

Name of Obstetrician/Midwife: _____
Complications during pregnancy? No Yes, List: _____
Ultrasounds during pregnancy? No Yes, Number: _____
Medications during pregnancy/delivery? No Yes, List: _____
Cigarette/Alcohol Use During Pregnancy? No Yes
Location of Birth (check one) Hospital_____ Birthing Center_____ Home_____
Birth Intervention: Forceps_____ Vacuum Extraction_____ C-Section: Emergency or Planned
Any complications after the birth? _____

5- Developmental History

Has your child ever fell head first from a high place in first year of life? _____
Has your child ever been involved in a car accident? _____
Has your child been seen on an Emergency Basis? _____
Has your child had prior surgery? _____

6- Health History(Circle No or Yes)

AIDS/HIV	N	Y	Migraine Headaches	N	Y
Allergy Shots	N	Y	Mononucleosis	N	Y
Anemia	N	Y	Mumps	N	Y
Anorexia	N	Y	Pinched Nerve	N	Y
Appendicitis	N	Y	Pneumonia	N	Y
Arthritis	N	Y	Polio	N	Y
Asthma	N	Y	Prosthesis	N	Y
Bleeding Disorders	N	Y	Psychiatric care	N	Y
Breast Lump	N	Y	Rheumatoid Arthritis	N	Y
Bronchitis	N	Y	Rheumatic Fever	N	Y
Cancer	N	Y	Rubella	N	Y
Chicken Pox	N	Y	Rubeola	N	Y
Diabetes	N	Y	Scarlet Fever	N	Y
Epilepsy	N	Y	Stroke	N	Y
Fractures	N	Y	Thyroid Problems	N	Y
Goiter	N	Y	Tonsillitis	N	Y
Hepatitis	N	Y	Tuberculosis	N	Y
Hernia	N	Y	Tumors, Growths	N	Y
High Blood Pressure	N	Y	Typhoid Fever	N	Y
High Cholesterol	N	Y	Ulcers	N	Y
Kidney Disease	N	Y	Vaginal Infections	N	Y
Liver Disease	N	Y	Whooping Cough	N	Y
Measles	N	Y	Other:	N	Y

Please list any:
Medications/Vitamins: _____
Allergies: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Dr.'s Notes: _____

Assignment and Release

Who is responsible for this account? _____ Birthdate: _____
Relationship to Patient: _____
Insurance Co. _____ Group # _____

Is patient covered by additional insurance? Yes No
Subscriber's Name: _____ Birthdate: _____ Relationship to Patient: _____
Insurance Co._____ Group# _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered/ I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of patient, parent/guardian or personal rep

_____
Please print name of patient, parent/guardian or personal rep

_____
Date

_____
Relationship to Patient