

The Mladenoff Clinic

Patient Billing Information

I understand that all payments are due to **The Mladenoff Clinic** at the time services are rendered. All bills are due and payable in full.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations.

Initial Consultation: No charge. (Initial consultation does not include any exams, x-rays or lab tests are subject to separate outside fees. All fees are subject to change without notice.

A charge of \$25.00 will be assessed for a missed appointment. We require a 24-hour notice for cancellations.

If your insurance company requests copies of your medical records, a charge of \$10.00 for copy charge as well as 10 cents per page will be billed to you. You may try to recover this charge from your insurance company.

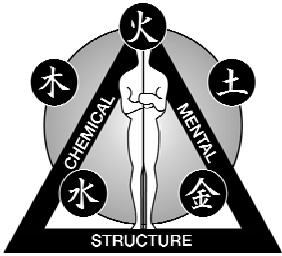
If you would like the Mladenoff Clinic to mail your receipt to your insurance company, please provide our staff with a copy of your insurance card.

I have read and understand how the payments are due and I agree to these policies and procedures.

Signature

Date

* This document will act as a lien against auto insurance in an automobile accident.



THE MLADENOFF CLINIC

NEW PATIENT INFORMATION

Client # _____ Today's Date: _____

PLEASE PRINT CLEARLY

Child's Name: _____ Date of Birth: _____

Address: _____ Home telephone: _____

Name(s) or Parent(s) or Guardian(s): _____ Business telephone: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child

Parent/Guardian Signature: _____ Date: _____ E-mail: _____

Name of Previous Doctor of Chiropractic: _____ Date of Last Visit: _____

Address: _____ City: _____ State: _____ Zip: _____

Home pH: (____) _____ Work Phone: (____) _____ Cell pH (____) _____

In case of Emergency contact: _____ Relationship: _____

Emergency contact phone # (____) _____ Name of Spouse/Parent/Guardian _____

How did you hear about the Mladenoff Clinic? Whom may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

- 1. The patient understands and agrees to allow the Mladenoff Clinic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.
- 2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.
- 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- 5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Mladenoff Clinic to assure that your records are not readily available to those who do not need them.
- 6. If a patients has a complaint about the privacy of records please see our office manager or Dr. Mladenoff.
- 7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature (Parent/Guardian) Date

Child's Height: _____ Child's Weight: _____

What are your chief concerns, if any, with your child's health?

What is your main reason for contacting us?

List any other care your child has undergone with regards to this complaint including medication:

Date of Onset: _____ Onset was (circle one): Sudden / Gradual / Associated with an event

Duration of problem (circle one) Minutes / Hours / Days / Months / Years

Pattern of Problem (circle one): Constant / Intermittent / Occasional / Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does this problem affect your child's body function and daily activities?

Prior occurrences or episodes? _____

Other health concerns? _____

History of Birth

Hospital / Birthing Center: Home Medical Midwife

Duration of Gestation ____ wks Was birth assisted? Yes No

If yes, how? forceps vacuum extraction C-section Induced Labor

Were medications given to mother at birth? Yes No If yes, what? _____

Was the delivery normal? Yes No If no, what complications were there at birth?

Duration of Birth _____ APGAR at Birth _____ APGAR after 5 min _____

Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, explain _____

What age did the child: Respond to sound? _____ Follow an object? _____

Hold up head? _____ Vocalize _____ Sit alone _____ Teethe? _____

Walk? _____ Do his/her sleeping patterns seem normal? Yes No

Describe any health problems that exist on the mother's side of the family? (eg Diabetes, Cancer)

The Fathers side? _____

Do the child's siblings have any health problems? ___ Yes ___ No If yes, describe _____

Chemical Stressors

During pregnancy, did the mother: 1. Smoke ___ Yes ___ No 2. Drink Alcohol? ___ Yes ___ No

3. Take supplements/vitamins ___ Yes ___ No 4. Take Drugs? ___ Yes ___ No

If yes, what? _____ 5. Become ill? If so, how? _____

6. Receive ultrasounds? ___ Yes ___ No If yes, how many? _____ 7. Receive invasive procedures(ie amniocentesis, CVS)? ___ Yes ___ No If yes, what? _____

Was your child breast fed? ___ Yes ___ No If yes, how long? _____

At what age was formula introduced? _____ What brand? _____

At what age was cow's milk introduced? _____ Solid food? _____

Did your child receive vaccinations? ___ Yes ___ No If yes, which ones? _____

Did your child react to them? ___ Yes ___ No

Has your child had antibiotics? ___ Yes ___ No If yes, how many courses and why? _____

Any pets at home? ___ Yes ___ No Any smokers at home? ___ Yes ___ No

Emotional Stressors

Any difficulties with lactation? ___ Yes ___ No Any problems bonding? ___ Yes ___ No

Does your child seem normal to you? ___ Yes ___ No

Does your child have any behavioral problems? ___ Yes ___ No If yes, what? _____

Does your child have difficulties sleeping (nightmares, bedwetting, sleepwalking)? ___ Yes ___ No If yes, specify: _____

Did your child go to daycare? ___ Yes ___ No From what age? _____

Average number of hours of TV/Computer per week? _____

Traumatic Stressors

Any evidence of trauma during birth? ___ Bruises ___ Odd shaped head ___ Stuck in birth canal ___ Excessively long birth ___ Respiratory Depression ___ Cord around neck ___ Other

Any falls/accidents during pregnancy? ___ Yes ___ No Describe _____

Has the child had any major falls since birth? ___ Yes ___ No If yes, did the child need stitches or cause a fracture? Describe _____

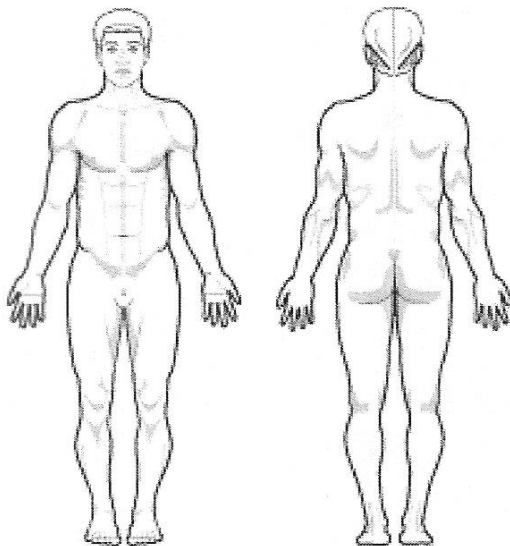
Any hospitalizations? ___ Yes ___ No Describe _____

Does your child play sports? ___ Yes ___ No Number of hours a week? _____

Age child began sports? _____

List and describe the problems you are having and draw them on the chart below.

1. _____
2. _____
3. _____
4. _____
5. _____



GRADE YOUR PAIN	
1 (= none) to 10 (= very severe)	
PROBLEM #	GRADE
1	1 2 3 4 5 6 7 8 9 10
2	1 2 3 4 5 6 7 8 9 10
3	1 2 3 4 5 6 7 8 9 10
4	1 2 3 4 5 6 7 8 9 10
5	1 2 3 4 5 6 7 8 9 10

ALLERGIES: Please check and list all allergies.

- Food: _____
- Seasonal: _____
- Environmental: _____
- Medications: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Drug Name	Date Started
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Arthritis Drugs		
<input type="checkbox"/> Behavioral Modification Drugs		
<input type="checkbox"/> Blood Pressure Lowering Drugs		
<input type="checkbox"/> Cholesterol Lowering Drugs		
<input type="checkbox"/> Hormone Replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

Scars/Surgical Procedures: List all scars and surgeries _____

Supplements: Does your child take Vitamins/Supplements Herbs/Homeopathics? If yes, who recommended them?

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
 (G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

- | | | | |
|---------------------------|-------------------|-----------------------|----------------------|
| ___ Alcoholism/Drug Abuse | ___ Eczema | ___ Miscarriage(s) | ___ Tumor(s) |
| ___ Anemia | ___ Emphysema | ___ Mumps | ___ Ulcers |
| ___ Cancer | ___ Epilepsy | ___ Pleurisy | ___ Vaccine reaction |
| ___ Cold Sores | ___ Goitre | ___ Pneumonia | ___ Other: _____ |
| ___ Deep Vein Thrombosis | ___ Gout | ___ Polio | _____ |
| ___ Detached Retina | ___ Heart Disease | ___ Rheumatic Fever | _____ |
| ___ Diabetes | ___ Hepatitis | ___ Seizures/Fainting | |
| ___ Diverticulitis / IBS | ___ HIV / ADIS | ___ Stroke | |

 Patient's Name (Printed)

 Parent/Guardian Signature

 Date: