Welcome to *Sugar Creek Chiropractic!*

Dr. Carrie Ross Thompson
112 Second St. W.
Chaska, MN 55318

Childs Information

Name _____

Parents/Guardians Name _____

Address _____ **City/State/** _____ **Zip**_____

DOB:_____/_____/_____ **Soc. Sec #:**_____-_____-_____

Home phone: _____ **Parent work Phone/s:** _____

Who referred you to us? _____

Email address_____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #:_____ **Group #:**_____

Insurer's Name (if different From Patient):_____ **Relationship to Patient:**_____

Insurer's DOB:_____ **Insurer's Soc. Sec #:**_____-_____-_____

Insurer's Employer:_____

Person responsible for account:_____

Is there a secondary Insurance? Y N If yes please provide info:

Insurance Name:_____

Member #:_____ **Group #:**_____

Insurer's Name (if different from Patient):_____ **Relationship to Patient:**_____

Insurer's DOB:_____ **Insurer's Soc. Sec #:**_____-_____-_____

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. Failure to provide secondary insurance information in a timely manner, all services will become patient responsibility.

Patient Name_____

Parent/Guardian Signature _____ **Date** _____

Print Name _____

8/12

Child's Health History

Past Chiropractic Care? Yes/No Dr.'S Name/Location _____

_____ **Last Visit** _____

Child's current Physician and Clinic: _____

Current Medical Care? Yes/NoWhy? _____

Current Drugs/Medication _____

Reason For Consulting This Office _____

_____

Please check any that apply

- ❑ Any illness during pregnancy?
- ❑ Drugs/medicine/tobacco/alcohol in pregnancy
- ❑ Labor chemically induced?
- ❑ Pulling or twisting during delivery?
- ❑ Forceps/Vacuum Extraction/C-section?
- ❑ Premature delivery?
- ❑ Vaccinations?
- ❑ Jaundice treatment?
- ❑ Colic?
- ❑ Eating or nursing problems?
- ❑ Sleeping problems?
- ❑ Falls in first year of life?
- ❑ Other falls or injuries?
- ❑ Respiratory problems?
- ❑ Ear infections?
- ❑ Allergies/Asthma?
- ❑ Digestive problems?
- ❑ Hyperactivity?
- ❑ Poor Nutrition?
- ❑ Auto Accident or Injury?
- ❑ Sports Injury?
- ❑ Family/Home Stress?
- ❑ Prescription Drug Use?
- ❑ Non-Prescription Drug Use?
- ❑ Ever Hospitalized?
- ❑ Surgery?
- ❑ Any Major Illness?
- ❑ Reoccurring Illnesses?
- ❑ Limited Exercise?
- ❑ Any other health related problems?

Explain: _____

Anything else? _____

I hereby authorize Dr. _____ and whoever may be designated as assistants to provide chiropractic care as may be deemed necessary to my child/ward: _____

Parent/Gaurdian Signature: _____ Date: _____

Chief Complaint:

Name:_____ Date: _____

1. Describe problem or illness: _____

_____

2. Did it start suddenly or gradually? (Circle answer) When did the problem start? ___/___/___
3. What do you think caused the problem? Please describe:

_____

5. What provokes the pain/ discomfort? (Check all that apply)

Sitting_____	Bending_____	Emotional stress_____
Standing_____	Running_____	Certain foods_____
Walking_____	Lying down_____	Other, _____ Please describe below:

_____

6. Have you seen any other doctors for this complaint? Yes / No (Please circle)

Name:_____	Name:_____
Treatment:_____	Treatment:_____
X-rays? Yes / No	X-rays? Yes / No

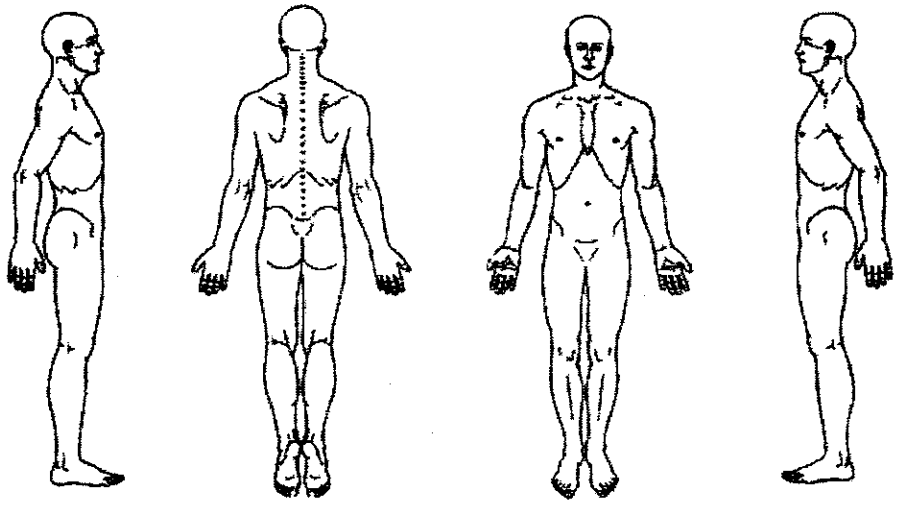
7. Is the pain: Mild____ Moderate_____Considerable_____ Severe_____
8. When does it occur? (Circle one) A.M. P.M. All the time
9. How long does the pain last? _____
10. Is it: (Check all that apply) Sharp_____ Dull_____Hot_____Tight_____Burning_____
Constant_____ Tingling_____ Numb_____Weak_____Other_____
11. Have you had this problem or similar condition before? _____
12. What other symptoms do you associate with this complaint? Describe:_____

_____

13. On a scale of 1 to 10 how would you rate your pain?

1 2 3 4 5 6 7 8 9 10

14. Using the diagram below, please mark the areas to help explain your complaint.



Carrie M. Ross Thompson, D.C.
Sugar Creek Chiropractic 112 W Second Street Chaska, MN 55318
Tel. (952)-448-2722

AUTHORIZATION TO TREAT MINOR AND RELEASE FORM

I, _____ ,the parent or guardian of the minor _____, am authorizing Carrie Ross Thompson,D.C. or an associate to treat and or examine the previously named minor.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my 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 or my dependents.

_____ Date _____

Signature of parent or guardian

_____

Signature of Chiropractor

Sugar Creek Chiropractic
112 2ND STREET WEST STE A
CHASKA, MN 55318-1908
952-448-2722
FAX-952-448-2768

SUGAR CREEK CHIROPRACTIC
112 WEST 2ND STREET STE A, CHASKA, MN 55318
952-448-2722

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Sugar Creek Chiropractic** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Sugar Creek Chiropractic's** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Sugar Creek Chiropractic** reserves the right to revise its Notice of Privacy Practices at any time. A review Notice of Privacy Practices may be obtained by forwarding a written request to **Sugar Creek Chiropractic** at 112 West 2nd Street Ste A, Chaska, MN 55318.

With my consent, **Sugar Creek Chiropractic** may call my home or other designated location any items that assist the practice in carrying out TPO, such as birthday cards and patient statements. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ By Initialing here, I am consenting to allow **Sugar Creek Chiropractic** to contact me via telephone, cell phone, text messaging, mail or email correspondence for the purpose of carrying out TPO. IF I do not have access to one or more of these modes of correspondence or prefer to not be contacted via a specific method I will list them here:

_____

By signing this form, I am consenting to **Sugar Creek Chiropractic's** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. IF I do not sign this consent, **Sugar Creek Chiropractic** may decline to provide treatment to me.

(PATIENT) PRINT NAME: _____

(GUARDIAN) PRINT NAME: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

Health Insurance Claim Form Signature Requirement

I AUTHORIZE THE RELASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS. I ALSO REQUEST PAYMENT OF INSURANCE AND/OR GOVERNMENT BENFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO **SUGAR CREEK CHIROPRACTIC** FOR DR. CARRIE ROSS THOMPSON, D.C. FOR SERVICES DESCRIBED ON MY SUBMITTED CLAIMS.

(PATIENT OR GUARDIAN) SIGN: _____ DATE: _____

Revised: 08/2019