



250 Newport Center Dr, Ste 102
Newport Beach, CA 92660
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Pediatric Patient History

Child's Name _____ Date of Birth _____
Mother's Name _____ Date of Birth _____
Father's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Mother's Mobile # _____ Mother's Email _____
Father's Mobile # _____ Father's Email _____
Mother's/Father's Driver's License #: _____ Mother's/Father's SS# _____
How were you referred to our office? _____
Insurance Carrier _____ Subscriber ID # _____
Subscriber's Name _____ Subscribers' Date of Birth _____
Reason for Today's Visit _____
Age _____ Sex: M ☐ F ☐ # of siblings _____
Current Weight _____ Current Height/Length _____ Birth Weight _____ Birth Length _____
Type of Birth: Normal Vaginal ☐ Forceps ☐ Cesarean ☐ Location: Home ☐ Birthing Center ☐ Hospital ☐
Problems during pregnancy: _____
Problems during labor/delivery: _____
Infant Feeding: Breast ☐ How Long? _____ Bottle ☐ How Long? _____ Which formula? _____
of hours child sleeps per night? _____ Quality of Sleep: Good ☐ Fair ☐ Poor ☐ _____
Water Intake: _____ Typical diet: _____
Exercise/Activities per day: _____
Vitamins/Medication: _____
Vaccination History: _____
Number of medications/antibiotics your child has taken in the past 6 months _____ his/her lifetime _____
Previous Chiropractor: _____
Date of last visit: _____ Purpose: _____
Pediatrician: _____
Past illnesses, surgeries and/or accidents and dates: _____
Family history of illnesses/diseases: _____

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed _____ Date _____

I agree that I am responsible for all fees charged by this office. I authorize release of this information to my insurance carrier.
I authorize payment directly to this doctor's office. I authorize a copy of this authorization to be used in place of an original.

Today's Date: _____ Signature: _____

Privacy Confidentiality Statement

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of Information

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Worker's Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

Appointment Reminder

It is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a message on your voice mail or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us the number you would prefer.

Facility Set Up

While our examination rooms are private, our office utilizes an open adjustment/therapy/exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

Your Rights

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances, they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment of health care operations, or the law otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is no cost for the first copy and any copy thereafter is \$25.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial amendment.
- You have the right to a copy of the notice upon request.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed to J.R. Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice.

By signing this form, I provide authorization and consent to use and disclose my protected information as noted above.

Patient Signature (or legal guardian) _____

Print Patient Name _____ Date _____

Informed Consent to Chiropractic Care

Tara Olivieri, D.C.
250 Newport Center Drive, Suite 102
Newport Beach, CA 92660

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above.

I will have the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations, sprains, and burns. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read, or had it read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature (or legal guardian) _____

Print Patient Name _____ Date _____

To be completed by Doctor or Staff:

Witness to Patient's Signature _____ Date _____