OVIEDO FAMILY
chiropractic

Dr. Eric Janowitz, D.C.

New Patient Application

Title: Mr. Mrs. Ms. Dr.

Last Name: ____________________ First Name: ______________ MI: ______

Nick Name: __________ Date of Birth: ___/___/___ SS #: ____-___-____ Marital Status: ____

Home Address: ____ Apt#: ________

City: ______________ State: ________ Zip: ________ Home Phone: (___) ___________

Cell Phone: (___) ______________ E-Mail ________________________

Work Phone: (___) ______________ May we contact you at work? ☐ Yes ☐ No

Employer Name: ________________________ Occupation: ______________

Insurance Co: ______________________ Ins ID #: ________________

Name of Insured: ______________________ Insured's Date of Birth: ___/___/___

Spouse Name: ______________________ Occupation: ______________

Financially responsible person if other than patient:

Last Name: ____________________ First Name: ____________ MI: ________

Address: ____

City: ______________ State: ________ Zip: ____________ Phone: (___) __________

Date of Birth: ____/____/____ SS#: ____-___-_____ Relationship to Patient: ______________

Employer Name: ________________________ Employer Phone: (___) __________

Emergency contact

Last Name: ____________________ First Name: ________________

Contact Phone: (___) ______________ Relation to patient: ______________

Referral Source:

Who may we thank for referring you to our office? ________________________

Or, where did you hear about our office? ________________________________

1813 East Broadway • Oviedo, Florida 32765 • (407) 359-2757 • Fax (407) 359-7464
www.OviedoFamilyChiropractic.com

Pediatric History Form

Dear Parent of a New Patient,

It is a pleasure to welcome you to our family of happy and healthy Chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help serve your child better, please complete the following information prior to their appointment in order for us to focus on discovering the cause of your child's health concerns.

Child's Name: ______________________ Date of Birth: ____________ Sex: Male Female

Names of Parents / Guardians : ______________________________________

CAUSE

The Human body is designed to be healthy. The primary system in the body which coordinates health is the Central Nervous System. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the Central Nervous System. The bones of the skill and the vertebrae of the spine house and protect the Central Nervous System.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses, which are common in our contemporary lifestyles, can result in misalignment and damage the spinal column. This interference is called Vertebral Subluxation Complex.

This form will help reveal the causes of the Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health potential.

Vertebral Subluxation Assessment

1. Purpose for contacting us? ______________________________________
2. Other Doctors seen for this condition (include Doctor's name and Prior Treatments)

   ____
3. Other Health Problems? ______________________________________
4. Check any of the following conditions that your child has suffered from:

   colic ***irregular sleeping patterns*** ***night sweats*** ***seizures*** ***tantrums*** ***ear infections***

   allergies ***asthma*** ***headaches*** ***poor digestion*** ***repeated infections or colds*** ***fevers***

   bed wetting ***learning disorders*** ***ADD or ADHD***
5. Family History: ______________________________________
6. Previous Chiropractor's name: ______________ Date of Last Visit: ____________

   Reason for care: ______________________________________
7. Name of Pediatrician: ______________ Date of Last Visit: ____________

   Reason for care: ______________________________________

   Are you satisfied with the Care your Child has received there? ____________

Prenatal and Past Health History on Next Page:

1. Name of Obstetrician / Midwife: ______________________________

2. Experts around the world agree. Intervention during the birth process may cause neurological trauma, damage and even death. According to the World Health Organization, children in twenty-two other countries have a greater survival rate than in the United States.
   a. Did the child's mother have ultrasound during this pregnancy? _____ how many? _____
   b. Place of birth: home ____ birthing center ____ hospital ____
   c. Type of birth: vaginal ____ induced labor ____ emergency c-section ____ planned c-section
   d. Medications during Pregnancy? ____ Type ________________________
   e. Medications during Delivery? ____ Type ________________________
   f. Cigarette / Alcohol use during pregnancy? ____
   g. What position did the mother deliver in? ____________________
   h. Birth Trauma: twisting, pulling _____ vacuum extraction _____ forceps _____
   i. Newborn trauma (medical procedures): ____________________

3. Repeated studies are now informing us that breast-feeding develops strong and healthy immune, neurological and digestive systems.
   a. Was your child breast fed? ____ How long? _________
   b. Was your decision supported by your health care provider? _________
   c. Formula fed for how long? __________ Type:__________________
   d. Introduced to solids at: ______ Months
   e. Food / Juice Allergies or Intolerances? ______ List: ______________________

4. According to the National Safety Counsel, approximately 50% of infants have fallen onto their heads their first years of life. Another study reveals that 250,000 children are injured at playgrounds annually. Can you recall such jolts, falls or traumas to your child?

   ____

5. Which of the following high impact sports does your child play? (i.e. Football, Soccer, Baseball, Basketball, Gymnastics, Karate, Hockey, Wrestling, Dance, Other)

   ____

6. Has your Child ever been involved in a car accident? ____ Describe: ________________

7. Has your Child been seen on an emergency basis? ____ Describe: ________________

8. Prior surgeries: ____

9. Other than five hours per day sitting in the classroom, does your child spend prolonged time sitting? _________ In front of a computer or Television? _________________

10. How would you rate your child's diet? ___________________________________

11. Number of doses of Antibiotics your child has taken:
    a. During the past 6 months: _______
    b. Total during his / her lifetime: ____________
12. Number of doses of Other Prescription or Over the Counter Medications your child has taken:
    a. During the past 6 months: _______
    b. Total during his / her lifetime: ____________
    c. List: ____
13. The child's immunes system, like all other developing systems of the body, is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term effects from interfering with this process with artificial vaccinations are just being uncovered. Were you adequately informed of the risks of vaccinating you child? _____ Did your child experience any behavioral, emotional or physical changes after any vaccination? ____ Please describe:

    ____
14. Chronic postures from either the parent or your child can be an indicator of stress on your child's nervous system.

    a. Do you, now or in the past, hold your child on only one hip or arm? ____
    b. If the crib was along a wall, was the child placed in opposite sides of the bed to prevent chronic one sided head rotation to see his parents? _____
    c. Have you noticed any head tilting that was more dominant on one side (while in a car seat, changing diapers, or laying down) ___ Describe: _______________________

CORRECTION

Today we are becoming more aware how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the Central Nervous System and the immune system function. The integrity of the Central Nervous System is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic; the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION TO TREAT A MINOR

I, ____________________, hereby authorize Dr. Janowitz and whoever he may designate as their representative to administer chiropractic care, as he may deem necessary, to my son/daughter ______________________________.
Dated this ___ day of ____________, 20____.

____________________________ ____________________________
Witness Name Parent/Legal Guardian Name

____________________________ ____________________________
Witness Signature Parent/Legal Guardian Signature

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

DR. ERIC JANOWITZ P.A. is hereby authorized to request the release of any medical records, laboratory test results, and radiographic & diagnostic imaging results, pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

DR. ERIC JANOWITZ P.A. is also authorized to release any medical records pertinent to the health care of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said DR. ERIC JANOWITZ P.A.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

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 Dr. Eric Janowitz 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 Dr. Eric Janowitz, including those working at the clinic

I understand I will have the opportunity to discuss with the doctors of Oviedo Family Chiropractic, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. 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 the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had 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.

YOUR FINANCIAL RESPONSIBILITY

Payment is due when services are rendered unless prior arrangements (including insurance participation) have been made. The individual(s) above understands that a $30 returned check fee will be charged should payments be made via check. The above individual(s) will also be responsible for any appropriate collection or attorney's fees which may accrue if it is necessary to engage collection services to pursue payment of any outstanding balance.

Patient Name: ______________________________

______________________________ ______________

Signature of patient or parent/legal guardian   Date

______________________________ ______________

Witness of patient or guardian's signature   Date

Oviedo Family Chiropractic
Patient Health Information Privacy Agreement
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Oviedo Family Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Oviedo Family Chiropractic**. I understand that diagnosis or treatment of me by **Eric Janowitz. D.C.** or other doctors at Oviedo Family Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Oviedo Family Chiropractic** is not required to agree to the restrictions that I may request. However, if **Oviedo Family Chiropractic** agrees to a restriction that I request, the restriction is binding on **Oviedo Family Chiropractic** and **Eric Janowitz. D.C.** Unless Oviedo Family Chiropractic is notified otherwise, I consent to being contacted by Oviedo Family Chiropractic by telephone, mail, or other electronic means in order to confirm appointments, advise me of any shift closings, provide newsletters, or invite me to any special events. I also consent to having my picture taken in order for the doctors to help analyze my posture.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Eric Janowitz. D.C.** or **Oviedo Family Chiropractic** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.

Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately and we can refer you to another chiropractor.

In addition, we may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

I understand I have a right to review and a copy has been provided to me, upon my request, **Oviedo Family Chiropractic** 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Oviedo Family Chiropractic**. The Notice of Privacy Practices for **Oviedo Family Chiropractic** is provided at 1813 East Broadway, Oviedo, FL 32765.

This Notice of Privacy Practices also describes my rights and the **Oviedo Family Chiropractic** 's duties with respect to my protected health information.

Oviedo Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________ ______________________________

Name of Patient or Personal Representative   Date

______________________________ ______________________________

Signature of Patient or Personal Representative   Description of Personal Representative's Authority