BELANGER CHIROPRACTIC LIFE CENTER

Specializing in Atlas Orthogonal Chiropractic   Sheila E. Belanger, D.C.

1003 East Freeway Dr. SE   Conyers, GA 30094

Phone 770-760-1394   Fax 770-760-8414

PEDIATRIC AUTOMOBILE ACCIDENT HISTORY FORM **(PLEASE PRINT)**

Minor Child's Name ______________________________ Date of Birth ______________

Date of Accident ____________ Time of Accident ________ AM / PM   ☐Daylight ☐Dawn ☐Dusk ☐Dark

City of Accident ______________ State of Accident ______ Street Address ______________________

Was accident on the job? ☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING INFORMATION AS IT PERTAINS TO THE MINOR CHILD NAMED ABOVE.

Road conditions at the time of the accident: ☐ **WET** ☐ **DRY** ☐ **ICY** ☐ **OTHER**: ______________________

Did the police come to the accident scene? ☐ **NO** ☐ **YES**   Is there a report? ☐ **NO** ☐ **YES**

Did you go to the hospital? ☐ **NO** ☐ **YES**, If *yes*, which hospital? ______________________

How did you get to the hospital? ______________ What areas of you were X-rayed? ______________

What did the hospital do for your injuries? (Collar, splints, medication, etc.) ______________________

How long did you stay at the hospital? ______________ What was their diagnosis? ______________

What did they recommended for follow-up care? ______________________

What bleeding cuts did you sustain during this accident? ______________________

What bruises did you sustain during this accident? ______________________

Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear-seat ☐ Other

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐ **AWARE** ☐ **SURPRISE**

Did you lose consciousness (black out) upon impact? ☐ **NO** ☐ **YES**, How long? ______________

Did you experience a flash of light or explosion in your head? ☐ **NO** ☐ **YES**

At the time of the accident, did you become or experience any of the following?

☐ Confused ☐ Disoriented ☐ Light headed ☐ Dizzy ☐ Nauseated

☐ Blurred vision ☐ Ringing / buzzing in ears ☐ Loss of balance ☐ Other

Do you still have any of those symptoms? If yes, which ones?

Check symptoms you have noticed since the accident.

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Light bothers eyes	☐ Buzzing in ears	☐ Diarrhea	☐ Neck pain
☐ Loss of memory	☐ Feet cold	☐ Neck stiff	☐ Pins and needles in arms
☐ Hands cold	☐ Fainting	☐ Sleeping problems	☐ Loss of balance
☐ Face flushed	☐ Pins and needles in legs	☐ Constipation	☐ Tension
☐ Numbness in fingers	☐ Loss of smell	☐ Fever	☐ Irritability
☐ Loss of taste	☐ Chest pain	☐ Cold sweats	☐ Shortness of breath
☐ Reduced tolerance to alcohol	☐ Stomach upset	☐ Ears ring	☐ Head seems too heavy
☐ Nervousness	☐ Numbness in toes	☐ Back pain	☐ Reduced tolerance to heat

Was any other doctor consulted after your accident? ☐ **NO** ☐ **YES**, If *yes*, who? ______________

What was the diagnosis? ______________ What was the treatment? ______________

How often did you see the doctor? ______________ For how long? ______________

Have you ever had any complaints in the involved area before? ☐ **NO** ☐ **YES**; If *yes*, what complaints: ______________

____

Have you been involved in any previous accidents? If so, when? ______________________

Are your work activities restricted as a result of this accident? ☐ **NO** ☐ **YES**

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Since the injury are your symptoms: ☐ Improving? ☐ Getting worse? ☐ Same?

Head-rest / restraint: ☐ None ☐ Integrated type ☐ Adjustable type ☐ Up ☐ Down ☐ Don't know

If adjustable, was the position altered by the accident? ☐ **NO** ☐ **YES**

Was the seat adjustment altered by the accident? ☐ **NO** ☐ **YES** Was the seat broken by the accident? ☐ **NO** ☐ **YES**

Did air-bag deploy? ☐ **NO** ☐ **YES,** If *yes*, did it strike you? ☐ **NO** ☐ **YES**

Were you wearing a seatbelt? ☐ **NO** ☐ **YES** ☐ **Don't Know** If *yes*, was it a: ☐ **lap belt** or a ☐ **shoulder-lap belt ?**

Did you receive any injury or bruise from the seat belt? ☐ **NO** ☐ **YES**

Check the following that were damaged during the accident: ☐ Steering wheel ☐ Windshield ☐ Seat ☐ Rear-view mirror

☐ Other:________________________

Was your body facing straight forward at the time of the collision? ☐ **YES** ☐ **NO,** How was it turned? ____________

Was your head pointed forward? ☐ **YES** ☐ **NO,** What direction was it turned and by how much? ____________

Where were your hands? ☐ One on the wheel ☐ Two on the wheel ☐ Not applicable

Were you wearing a hat or glasses at the time of impact? ☐ **NO** ☐ **YES** Were they still on after the accident? ☐ **NO** ☐ **YES**

YOUR CAR:

List the year, make and model of the car you were in: YEAR:________ MAKE:________ MODEL:________

Was your car stopped at the time of impact? ☐ **NO** ☐ **YES;** If *yes*, was the driver's foot on the brake? ☐ **NO** ☐ **YES**

If ***no***, then estimate the speed of the vehicle you were in: ______ MPH

If your vehicle was moving at the time of impact, was it: ☐ Slowing down ☐ Gaining speed ☐ Steady speed

What is the estimated cost of damage to the vehicle you were in? **$**

THE OTHER CAR:

What is the year, make and model of the other vehicle? YEAR:________ MAKE:________ MODEL:________

Was the other vehicle moving at the time of collision? ☐ **NO** ☐ **YES;** If *yes*, what was the approximate speed? ______MPH

At the time of impact, was the other vehicle: ☐ Slowing down ☐ Gaining speed ☐ Steady speed

Estimate the damage to the other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Please describe, to the best of your knowledge, what happened during this accident.

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in:____________ Name of their auto insurance:________

Owner of the automobile you were in:____________ Name of their auto insurance:________

Insurance company phone#:____________ Claim#: ____________

Driver of the other automobile:____________ Name of their auto insurance:________

Owner of the other automobile:____________ Name of their auto insurance:________

Insurance company phone#:____________ Claim#: ____________

Note: A lien may be filed on personal injury accounts.

Have you retained an attorney? ☐ **NO** ☐ **YES, Name and Phone #:** ____________

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PEDIATRIC PATIENT HISTORY FORM

(PLEASE PRINT)

Dear 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 us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Minor Child's Name ______________________________ Date of Birth ____________________

Name of Parents / Guardians ______________________________ Phone ____________________

Referred By: ____

Purpose for contacting us?____

Other doctors seen for this condition: □ YES □ NO If yes, doctors' names and prior treatments:____________________

____

Other health problems?____

Check any of the following conditions your child has suffered from during the past Six Months.

□ Ear infections	□ Scoliosis	□ Seizures	□ Chronic colds	□ Headaches
□ Asthma / Allergies	□ Digestive problems	□ ADHD / ADD	□ Recurring Fevers	□ Growing / Back Pains
□ Colic	□ Bedwetting	□ Car accident	□ Temper Tantrums	□ Other:__________

Family History:____

Previous Chiropractic care: □ NO □ YES, Chiropractor name:______________________________

Date of last visit: ______/______/______ Reason:______________________________

Name of Pediatrician:____

Date of last visit: ______/______/______ Reason:______________________________

Are you satisfied with the care your child has received there? □ YES □ NO

Number of doses of **Antibiotics** your child has taken:

During the past Six Months:_______ Total during his / her lifetime:_________

Number of doses of **Other Prescription Medications** your child has taken:

During the past Six Months:_______ Total during his / her lifetime:_________ List:____________________

Vaccination History □ All □ Some □ None:______________________________

Prenatal History:

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: □ Hospital □ Birthing Center □ Home

Birth intervention: □ Forceps □ Vacuum Extraction □ Caesarian: Emergency or Planned?

Complications during delivery? □ NO □ YES, List:______________________________

Genetic disorders or disabilities? □ NO □ YES, List:______________________________

Birth Weight:________________ Birth Length:________________ APGAR Scores: ___________________ , ___________________

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Feeding History:

Breast fed? ☐ NO ☐ YES, How Long:____________________

Formula fed? ☐ NO ☐ YES, How Long:____________________ Type:____________________

Introduced to solids at:______________ months, Cow's milk at:______________ months

Food / Juice Allergies or Intolerance? ☐ NO ☐ YES, List:____________________

____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). *At what age was your child able to:*

Respond to Sound:____________________

Respond to Visual Stimuli:____________________

Hold Head Up:____________________

Sit Up:____________________

Cross Crawl:____________________

Stand Alone:____________________

Walk Alone:____________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc). *Was this the case with your child?* ☐ NO ☐ YES

Is / has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ NO ☐ YES, List:____________________

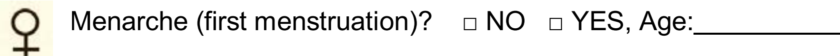
____

Has your child ever been involved in a car accident? ☐ NO ☐ YES, List:____________________

Has your child been seen on an emergency basis? ☐ NO ☐ YES, List:____________________

Other traumas not described above? ☐ NO ☐ YES, List:____________________

Prior surgery? ☐ NO ☐ YES, List:____________________



Menarche (first menstruation)? ☐ NO ☐ YES, Age:__________

Childhood Diseases:

Chicken Pox? ☐ NO ☐ YES, Age:__________

German Measles / Rubella? ☐ NO ☐ YES, Age:__________

Whooping Cough? ☐ NO ☐ YES, Age:__________

Mumps? ☐ NO ☐ YES, Age:__________

Measles / Rubeola? ☐ NO ☐ YES, Age:__________

Other:____________________, Age:__________

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

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: *I hearby authorize the doctor(s) at* ***Belanger Chiropractic Life Center*** *and whomever they designate as assistants to administer chiropractic care to my:* ☐ son ☐ daughter ☐ grandson ☐ granddaughter ☐ ____________________

Name of Minor Child (PLEASE PRINT)**:**____________________

Name of Minor Child's Parent / Guardian / Responsible Party (PLEASE PRINT)**:**____________________

Signed:____________________ **Dated:**____________________

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AUTHORIZATION AND ASSIGNMENT
for Minor Child

In consideration of your undertaking to treat me, I hereby agree to the following:

1. Dr. Sheila Belanger is authorized to release information deemed appropriate concerning my condition to any insurance company or adjuster in order to process any claim for reimbursement of charges incurred by me;

2. I authorize the direct payment to Belanger Chiropractic Life Center (BCLC) of the sum I owe by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for charges for your services or otherwise obligated to make payment to you based in whole or in part upon the charges made for your services;

3. In the event any insurance company obligated by agreement to make payment to me or BCLC for the charges from your services refuses to make payment upon request by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company. However, it is understood that I am personally responsible for any amounts owed to BCLC.

Date: ______________________________

Signature: ______________________________
parent, guardian, or responsible party of minor child

Print Names:

Parent, Guardian, or Responsible Party: ______________________________

Minor Child: ______________________________

BELANGER CHIROPRACTIC LIFE CENTER
1003 East Freeway DR SE Conyers, GA 30094

Provider Name: Sheila E. Belanger, DC
NPI #: 1508995770

HIPAA Compliance

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO OUR OFFICE

Health Care Facilities make and keep records of medical information. While you are a patient of Belanger Chiropractic Life Center, we will use and disclose your medical information:

To provide treatment to you and keep a record describing your care
To receive payment for the care we provide
To comply with law

We are required by law

To keep your medical information confidential in accordance with legal requirements
To give you this Notice of our legal duties and privacy practices with respect to your medical information
To follow the terms of the Notice that is currently in effect

YOU MAY REQUEST A FULL COPY OF THIS NOTICE AT ANY TIME.

Summary of HIPAA Compliance Regarding Payment

Payment. We may use and disclose your medical information so that the treatment and services you receive can be billed and collected from you, an insurance company or another third party. For example, we may give your health plan or a third party information about treatment you received so your health plan or the third party will pay us for the treatment.

Patient: List any possible payors, insurance companies & individuals, that may be responsible for your treatment at *Belanger Chiropractic Life Center.* *THE FOLLOWING PAYORS, INSURANCE COMPANIES AND INDIVIDUALS, SHOULD ADHERE TO THIS HIPAA Compliance Agreement:*

Automobile Insurance Carrier	*Address*	*Phone / Fax*
Automobile Insurance Carrier	*Lawyer/Attorney's Office*	*Other*
Automobile Insurance Carrier	*Lawyer/Attorney's Office*	*Other*

PLEASE READ CAREFULLY:

I hereby authorize any clinical record technician at Belanger Chiropractic Life Center to use and/or disclose my Protected Health Information on behalf of SHEILA E. BELANGER, DC in accordance with the Health (HIPAA) My signature below also authorizes the release of my Protected Health Information to any of the above listed payors strictly for the process of all claims performed by SHEILA E. BELANGER, DC to be paid directly to Belanger Chiropractic Life Center on my behalf. I understand that I am responsible for any unpaid balances due.

A photocopy or facsimile of this authorization may be used in lieu of the original.

By signing below, I have read and accept the above terms and conditions.

(PRINTED) Patient's Name	***Patient Signature***	***Date of Signature***