Date: _____
Child's Name:_____ DOB:
_____
Parent's/Guardian's Name(s):
_____
Phone Number: (H) _____ (C)
_____
Address:
_____
E-mail Address:
_____
Has your child been checked by a Doctor of Chiropractic? ▫ Yes ▫ No
Were x-rays taken: ▫ Yes ▫ No
Name of Pediatrician:
_____

Birth History
Any pregnancy complications? ▫ Yes ▫ No If yes, explain:
_____
Place of birth:
_____
Type of birth: ▫ Vaginal ▫ C-Section

Health History
Has your child had any health problems?
_____
Does your child have any food or other allergies?
_____
Is your child currently taking any medications?
_____
Vitamins? ▫ Yes ▫ No
_____

Baby/Toddler (0-4): Have any other of the following occurred?
- ▫ Tumble down stairs
- ▫ Fall out of crib
- ▫ Involved in auto accident
- ▫ Fall off playground equipment
- ▫ Frequent ear infections
- ▫ Tonsillitis
- ▫ Other, please explain:

_____

- ▫ Frequent fevers
- ▫ Frequent bouts of diarrhea
- ▫ Constipation
- ▫ Sleeping problems
- ▫ Repeated infections or colds
- ▫ Colic

Child (5-12): Have any other of the following occurred?
- ▫ Fall from a tree/playground
- ▫ Fall off a bicycle
- ▫ Sports accident
- ▫ Involved in auto accident
- ▫ Scoliosis

- ▫ Hyperactivity
- ▫ Asthma
- ▫ Allergies
- ▫ Leg/knee pains
- ▫ Other, please explain:

_____
Which of the above bothers your child the most:
_____
When did it begin? _____ Is it getting worse? ▫ Yes ▫ No

Is the pain constant? ▫ Yes ▫ No If yes, is it: ▫ Severe ▫ Moderate ▫ Mild

How much has it affected daily life? ▫ Always ▫ Frequently ▫ Somewhat ▫ Not at all

Is there anything else we should know about your child?
_____
_____
_____

Authorization to Treat a Minor

I, _____, the undersigning parent/legal guardian of _____, a minor, do hereby authorize, request and direct Shaun E. Rinow, DC and/or whomever he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient Name (please print): _____

Signature (Parent/Legal Guardian):
_____

Date: _____

INFORMED CONSENT

PATIENT NAME

Dr. Shaun E. Rinow
Integrity Sport & Spine Chiropractic Center
100 Biddle Avenue
Suite 102
Newark, DE 19702
302-595-2344

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a chiropractic adjustment. As the joints in your spine are moved, you may hear a "pop" as part of the process.

There are certain complications that can occur as a result of a chiropractic adjustment. These compilations include, but are not limited to: muscle strain, fractures, costovertebral strains and separation. Extremely rare complications include, but are not limited to stroke. The most common complication or complaint following a chiropractic adjustment is an ache or stiffness at the site of adjustment.

I am aware of these extremely rare complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, please let us know while taking your clinical history.

DATE

Printed Name

Signature

Signature of Parent or Guardian (if a minor)

Assignment of Benefits – Policy of Payment

Assignment of Benefit:

I hereby assign all medical benefits, to include Major Medical benefits to which I am entitled, including Medicare, private insurance, auto (PIP/Med pay) and any other health plans to **Integrity Sport & Spine Chiropractic Center, LLC.**

I agree that all payments are to be payable solely to and sent directly to Dr. Shaun E. Rinow,
100 Biddle Avenue, Suite 102, Newark, DE 19702, regardless of any other agreements or contracts I may enter into with any attorney or any other individual, group or other company subsequent to this date.

Policy of Payment:

We will file your claim forms and assist you in every way we can. However, the contract is between you and your insurance company and you are fully responsible for any account not paid by insurance plan. Our office does **NOT** guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your claim is denied or your policy changes, and changes affect the verification received from your insurance company, you will be responsible for the full amount of your bill. Our office will **NOT** enter into dispute with your insurance company over your claim. This is your responsibility and obligation.

My signature affirms all of the statements made above.

Signature:_____

Printed Name: _____

Date: _____