MOREA
Chiropractic Wellness Center
(231) 865-7474 | MoreaChiro.com

Dr. Michael Morea
388 N Third Ave, Suite L, Fruitport MI 49415
P: (231) 865-7474 F: (231) 865-7484

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

Authorization for Care of Minor

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

Signed: _____ Witnessed: _____ Date: _____

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HIPPA PRIVACY PRACTICES

I acknowledge that Morea Chiropratic Wellness Center, PLC "Notice of Privacy Practices" has been made available to me. I understand I have the right to review Morea Chiropratic Wellness Center's Notice of Private 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 healthcare operations at Morea Chiropratic Wellness Center.

The Notice of Privacy Practice is also posted on our website at www.moreachiro.com. It is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Morea Chiropratic Wellness Center, duties with respect to my protected health information. LMorea Chiropratic Wellness Center, 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 by asking for one at the time of my next appointment.

Please list below the names of person(s) authorized to gain access to patient account information:

_____

_____

PRIVACY & COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Written communication will be sent to the address specified on your patient intake unless you request otherwise.

I would like Appointment Reminders by:

❒ Text - Cell phone number_____Cell phone provider_____

❒ Phone – number _____

❒ Work phone _____

Email communication: ❒ I give my permission to send occasional emails with birthday gifts, news, specials, and events.
(We will not sell or give your address to third parties)

INFORMED CONSENT

The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history 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, you should let us know when we take your clinical history.

_____

Print Name ***Signature*** ***Date***

****

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____

Name Patient Representation (parent, guardian) ***Signature*** ***Date***

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ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, I acknowledge that I have been provided a copy of the Morea Chiropratic Wellness Center, Policies and Payment Policy. I have also been notified of the HIPAA Policy and Privacy Practices utilized in this office. Copies are posted on our website at www.moreachiro.com It is also provided upon request at the main administration desk.

I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees.

Upon placement of your delinquent account with a third party collector (eg. collection agency or collection law firm), you will be responsible for and your account will be assessed, a collection fee in the amount of 33.33% of the then outstanding balance.

My signature also authorizes the payment be made directly to Morea Chiropratic Wellness Center for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.

Morea Chiropratic Wellness Center reserves the right to transfer account credits within a family to settle balances due.

I understand and agree that Morea Chiropratic Wellness Center has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.)

I authorize the staff of Morea Chiropratic Wellness Center to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature of Patient/ Patient Representation (parent, guardian) ***Date***