

## Pediatric New Patient Information

Today's Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's Nickname \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Sex: M / F    Date of Birth: \_\_\_\_\_    Age: \_\_\_\_\_    Child's SS#: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Child's Home: \_\_\_\_\_

How did you hear about our office or website? (Please list where you've seen/heard about our office or what web search you used.) \_\_\_\_\_

### Family Information

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_

Parent's Marital Status:    Married \_\_\_\_\_    Single \_\_\_\_\_    Divorced \_\_\_\_\_    Widowed \_\_\_\_\_

List Ages of Other Children in Family: \_\_\_\_\_

Predominant Language Used at Home: \_\_\_\_\_

### Payment Information

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: \_\_\_\_\_    Birth Date: \_\_\_\_\_    SS#: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_    Phone #: \_\_\_\_\_

Insurance Company Address to send claims: \_\_\_\_\_

Employer: \_\_\_\_\_    Group #: \_\_\_\_\_    Insured's ID #: \_\_\_\_\_

### Consent to Treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named \_\_\_\_\_ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parents Name: \_\_\_\_\_    Signature: \_\_\_\_\_

Date : \_\_\_\_\_    Witnessed by: \_\_\_\_\_