Child's Name	Pediatric New Patient Information		
Reason for visit:  Sex: M / F Date of Birth: Age: Child's SS#:	Today's Date		
Sex: M / F Date of Birth: Age: Child's SS#: Child's Home Address: Child's Home Phone #: 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.) Father's Name: Father's Name: Home Phone #: Home Phone #: Home Phone #: Home Phone #: Work/Cell 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: Phone #: Insurance Company Address to send claims: Phone #: Insurance To 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: Signature:	34		
Child's Home Address:  Child's Home Phone #:  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:  Home 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:  Birth Date:  SS#:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Employer:  Group #:  Insurance Company Address to send claims:  Em			
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Work/Cell Phone:	Home Phone #:	Home Phone #:	
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Predominant Language Used at Home:	Parent's Marital Status: Married	Single Divorced Widowed	
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