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 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: _____ 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: _____