

# PEDIATRIC NEW PATIENT INFORMATION

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

## PATIENT INFORMATION

Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

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

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

Home Address: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## FAMILY INFORMATION

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

Does one or both parents have custody? \_\_\_\_\_

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

Work Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

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

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

## PAYMENT INFORMATION

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

If you have health insurance that may cover chiropractic care, 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: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

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

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

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

## CONSENT FOR CHIROPRACTIC CARE

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 (name) \_\_\_\_\_ as the doctor deems necessary.

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

Guardian's Name (Printed) \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

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