



# PEDIATRIC NEW PATIENT INFORMATION

Date: \_\_\_\_\_

## PATIENT INFORMATION

Child's Name: \_\_\_\_\_ Child's Nickname: \_\_\_\_\_

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

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

Child's Home Phone #: \_\_\_\_\_

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

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

## FAMILY INFORMATION

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

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

Work Phone #: \_\_\_\_\_ Work 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 No: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Group No: \_\_\_\_\_ 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 the I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: \_\_\_\_\_ Signature \_\_\_\_\_

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