

Pediatric New Patient Information
(Please fill in the child's information)

PATIENT INFORMATION: Gender: M / F Date: ___/___/___ Apt time: ___:___ am/pm
Name: _____ D.O.B.: ___/___/___ Age: ___ Childs SS#: ___-___-___
Address: _____ Phone: (____)-____-____

Reason for Visit (***Please circle all that apply or describe below***):

*Colic *Reflux *Ear Infections *Behavior Disorders *Bed wetting *Sports Injury

Other: _____

Pediatrician Name: _____ (Phone): (____)____-____

Who may we thank for referring you? _____

FAMILY INFORMATION:

Mother's Name: _____ Father's Name: _____

Home Phone #: _____ Home Phone #: _____

Other Phone #: _____ Other Phone #: _____

Parent's Marital Status (please check): Married ___ Single ___ Divorced ___ Widowed ___

List ages of other children in family _____

PAYMENT INFORMATION:

Please read and sign our financial agreement:

If you have insurance that may cover chiropractic services, please provide your current insurance care 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: _____ D.O.B.: ___/___/___ S.S.#: ___-___-___

Insurance Company Name: _____ Phone #: (____)-____-____

Insurance Company Address to send claims: _____

Employer: _____ Group #: _____ Policy 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: ___/___/___

(Please note; additional forms specific to your child's age will be given by our front desk staff when you arrive to our office; please fill them out completely.)