Name:_____

Date: _____

File#:_____

SPINAL HEALTH & WELLNESS

PEDIATRIC NEW PATIENT INFORMATION

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: _____

How did you hear about us? _____

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 doctor 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.

Patient's Name: _____ Signature _____

Date: _____ Witnessed by: _____