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 #:	
FAMILY INFORMATION	
Mother's Name:	Father's name:
Home Phone #:	Home Phone #:
Work Phone #:	
Parent's Marital Status: Marrie	ed Single Divorced Widowed
List Ages of Other Children in Family:	
Predominant language used at home: _	
PAYMENT INFORMATION	
Please read and sign our Financial Agree	eement. Does your health insurance cover chiropractic? Y/N
	niropractic services, please provide your current insurance card so that we may the following information relating to the person who is responsible for the
Insured's Name:	Birth date: SS #:
Insurance Company Name:	Phone No:
Insurance Company Address to send cla	aims:
Employer:	Group No: Insured's ID #:
CONSENT TO TREAT	
Being the parent or legal guardian of th	is child, I hereby authorize this office and its doctors to examine and
administer care to my son / daughter na	med as the
	ssary.
examining / treating doctor deems nece	ally responsible for payment of all fees charged by this office for such care.
I understand and agree the I am persona	Signature