Patient Information about your child

Patient Name:_____ SSN#:____-____-_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____

D/O/B:_____ Height:_____ Weight:_____ Sex: Male Female

Parents/Guardian Name(s):_____

Parent Daytime Contact Number:_____

Whom do we thank for your referral?_____

Insurance Information

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co_____ Group #_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance and assign directly Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature_____

Relationship_____ DOB_____ Date_____

What is the health issue you have contacted us about?_____

Have you seen other doctors for this condition? Yes No

Doctors names and the treatment they recommended:_____

Are there any other health problems?_____

Please circle any of the following conditions your child has suffered from in the past.

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Colic	ADHD/ADD	Recurring Fevers	Growing /Back pains
Digestive Problems	Bed Wetting	Car Accident	Sleep Issues	Other_____

Are there any chronic diseases or health concerns in your family?_____

Previous Chiropractor:_____ Date of Last Visit:_____

Name of Pediatrician?_____ Date of Last Visit:_____

Has your child been on any medication? Yes No List:_____