Pediatric Client Information & Permission to Treat

To Be Filled Out by Parent or Guardian of Any Client under 18

CLIENT/PATIENT INFORMATION

Child's First Name:_____ MI_____ Last Name:_____

Gender: **M F** Date of Birth (MM/DD/YYYY):_____ Age:_____
Phone#:_____

Primary Reason for Visit:_____

FAMILY INFORMATION:

1st Parent Name:_____ 2nd Parent Name: _____

Home/Cell Phone:_____ Work Phone:_____

Home/Cell Phone:_____ Work Phone:_____

PAYMENT INFORMATION:

Does your health insurance cover Chiropractic Care?: **Y N** Massage Care?: **Y N**

If you have health insurance that may cover your child's treatment, please provide your current insurance card and the ID of parent (and child,if available) 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 (as it appears on card): _____ Date of Birth: _____

Insurance Company Name: _____ Phone Number: _____

Insurance Company Address to send claims:_____

Insured's Employer: _____ Group #:_____ ID number:_____

CONSENT TO TREAT:

Being the parent or legal guardian of this child, I hereby authorize this office and its service providers to administer care to my child (name) _____ as the practitioners deem necessary.

Parent/Guardian Name (Please Print):
_____

Signature: _____ Date:
_____

Witnessed By: _____ Date:
_____