

**CONNECTICUTchiropractic****PEDIATRIC NEW PATIENT INFORMATION**

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 # \_\_\_\_\_

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 \_\_\_\_\_

Predominant language used at home: \_\_\_\_\_

**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 doctors to examine and administer care to my son / daughter \_\_\_\_\_ 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.

Parent's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witnessed by: \_\_\_\_\_