Pediatric New Patient Information

Date:_____

PATIENT INFORMATION

Child's Full Name:_____ Nickname:_____
Reason for visit:_____
Sex: M / F Date of Birth:_____ Age:_____ 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 #:_____
Parents marital status (please circle): Married Single Divorced Widowed
List ages of other children in family:_____
Language used at home:_____

PAYMENT INFORMATION

Please read and sign our Financial Agreement.

- I hereby understand that any and all payments are due at time of service and any returned check and/or any NSF(Non-Sufficient Funds) are subject to a $25 fee and will be charged to me directly.
- I authorize the release of information by any media pertinent to my case to any insurance company, adjuster, or attorney, involved in my case and verification of employment. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible to New Spring Chiropractic for all charges incurred and not covered by the insurance, workers compensation, and any collection, thirty-three and one third per cent (33 1/3%) attorney fees, interest and/or cost accrued in trying to collect this amount..
- I understand any balances over 30 days are subject to accrued interest of 1.5 percent per month.
- I have read all information in this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Patient's Guardian Signature:_____Date:_____

CONSENT TO TREAT

I, parent or legal guardian of this child, hereby authorize this office and it's doctors to examine and administer care to my son / daughter named above 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:_____

NEW SPRING CHIROPRACTIC

CHILD'S HISTORY

1-12 years

Today's Date:_____

Child's Name:_____ Sex: M / F Date of Birth: _____

Mother's Name:_____ How many children do you have? _____

Reason for today's visit?_____

When did this problem occur?_____

YES NO

☐ ☐ Has this problem happened before? _____

☐ ☐ Have you previously been treated for this?_____

☐ ☐ Have you previously been to a chiropractor? _____

About Child's Health

In the past year, have you had any of the following?

YES NO

☐ ☐ Back or neck pain? _____

☐ ☐ Pains in the legs or arms?_____

☐ ☐ Headaches?_____ _____

☐ ☐ Asthma? _____

☐ ☐ Allergies?_____

☐ ☐ Earaches?_____ _____

☐ ☐ Falls from a bicycle, skateboard, or similar?_____

☐ ☐ Do you have a problem with bedwetting? _____

☐ ☐ Have you ever been in a car accident?_____

☐ ☐ Have you ever had any broken bones?_____

☐ ☐ Have you ever had any surgeries?_____

☐ ☐ Are you taking any medications?_____

☐ ☐ Do you have any other health concerns?_____

_____

Child's height:_____ Child's weight:_____