PATIENT INFORMATION

Date: _____
Patient Name: _____ Day Phone:_____
Address: _____ Night Phone:_____
City: _____ State:____ Zip:_____ Cell Phone:_____
Date of Birth: ___/___/___ Age: _____ Patient's Social Security Number: ____ - ____ -____
E-mail Address: _____
Mother's Name: _____ Occupation: _____
Father's Name: _____ Occupation: _____
Referred to this office by: Friend/Relative Yellow Pages Insurance Company Other

INSURANCE INFORMATION

Who is responsible for this account? _____
Insurance Company: _____
Group Number: _____ ID Number:_____
Subscriber's Name: _____ Employer: _____
Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____
Relationship to patient: _____

Is patient covered by additional insurance? Yes No
Insurance Company: _____
Group Number _____ ID Number_____
Subscriber's Name: _____ Employer: _____
Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____
Relationship to Patient: _____

Name of Pediatrician: _____ Location of Pediatrician_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to 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 hereby 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.

I also hereby authorize Dr. _____ and whomever she may designate as assistants to administer chiropractic care as deemed necessary for _____ (name of child).

I give Dr. _____ permission to contact my child's pediatrician regarding his/her care? Yes No

_____ _____
Responsible Party Signature Relationship