

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