CHILD PATIENT INFORMATION

PERSONAL INFORMATION

Full Name ______________________________

Date of Birth ______________ **Social Security** ______________ Male Female

Address ______________________________

City ______________ **State** ______________ **Zip** ______________

Phone Number ______________ **E-Mail** ______________

How did you hear about us? Social Media Internet Search Friend/Relative ______________

Name of person who referred you

INSURANCE INFORMATION

Insurance Company ______________ **Policy Holder** ______________

Insurance Company ______________ **Policy Holder** ______________

Policy Number ______________ **Policy Holder DOB** ______________

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REASON FOR YOUR VISIT

☐ General Wellness ☐ Slip/Fall ☐ Auto Accident ☐ Home Injury

☐ Pain ☐ Sports Injury ☐ Work Injury ☐ Other/Unknown

How long have you had this complaint: ☐ less than 5 days ☐ between 5-30 days ☐ more than 30 days

Brief description of fall/injury/accident:

PARENT/LEGAL GUARDIAN CONSENT

Name ______________ **Relationship** ______________ **Phone #** ______________

I, ______________________________, parent/legal guardian of ______________, have the legal right to authorize this clinic to provide medical care to the minor named above. I request and authorize Andover Spine and Health Center and its personnel to deliver medical care as deemed necessary, including, but not limited to, x-rays and chiropractic adjustments.

Signature: ______________________________ **Date:** ______________

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I"m responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: ______________________________ **Date:** ______________

Andover Spine and Health Center
105 S. Andover Road, Suite E
Andover, KS 67002