NEWBOLD CHIROPRACTIC

PHONE 650-726-3300

Pediatric New Patient

Today's Date: _______________Name: ____

Name you prefer to be called: ____________________ Birthday: ______________ Age: ______

Name of Parents / Guardians: ____

Mailing Address: ____

Home Phone: ___________________ Work: __________________ Cell: ___________________

Email (to receive newsletter, will not be given out): ____________________________________

How did you hear about us?____

INSURANCE INFORMATION

Insured's Name: ___________________________Relationship to Patient: __________________

Insured's Date of Birth: ______________________Insured's SS #: ________________________

Name of Insurance Company: ____

ID #: _________________________________Group Number: ___________________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. Signature __________________________________ Date_________________

CONSENT TO TREATMENT OF MINOR

I (We), being the parent or guardian of ______________________________ , a minor, the age of ______ do hereby consent , authorize and request this office and its Doctors to administer such treatment deemed advisable, necessary, or requested on the above minor.

I (We) agree to hold this office and its Doctors free and harmless from any claims, suits for damages, or complications which may result from such treatment.

Signed ____ Date___________________

Witnessed ____