



Patient Information Sheet

Child Information

Child's Name _____ Male Female Date of Birth _____
Address _____ City _____ State _____ Zip Code _____
Referred by _____
Physician's Name _____ Physician's Phone (____) _____

Parent Information

Mother's Name _____ Home Phone (____) _____ Cell (____) _____
Address (if different) _____ City _____ State _____ Zip Code _____
Social Security Number _____ Date of Birth _____
Email Address _____
Occupation _____ Work Phone (____) _____
Employer _____

Father's Name _____ Home Phone (____) _____ Cell (____) _____
Address (if different) _____ City _____ State _____ Zip Code _____
Social Security Number _____ Date of Birth _____
Occupation _____ Work Phone (____) _____
Employer _____

Emergency Information

 Please list a local person, other than listed above, that we can contact in an emergency should we be unable to reach either parent.

Name _____ Relation _____
Home Phone (____) _____ Work Phone (____) _____

Insurance Information

Employer _____
Name of Insurance Company _____
Phone (____) _____ Policy Number _____
As the responsible party I agree to provide payment for all services regardless of insurance coverage.
Signature of Responsible Party _____ Date Signed _____

Office Policy Information

 (Please initial the items below)

_____ Insurance co-payments and deductible are payable at the time of service.
_____ Insurance claims will be submitted to your provider for you following treatment.
_____ If an appointment must be cancelled, please notify the office at least 24 hours in advance.
_____ We reserve the right to charge for a broken or cancelled appointment with less than 24 hours notice.
