PEDIATRIC PATIENT INFORMATION

Thank you for choosing Body First Chiropractic LLC. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information.

1 PATIENT INFORMATION

Date_____ **Patient's Social Sec. #**_____-_____-_____ **Date of Birth** _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Parent First Name _____ **Middle Initial** _____ **Last Name** _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____**)** _____ **Work (**_____**)** _____ **Cell (**_____**)** _____

Email _____ **Employer** _____ **Occupation** _____

In case of emergency contact Name _____ **Relationship** _____

Home (_____**)** _____ **Work (**_____**)** _____

Who were you referred by: _____

Please complete the following section and present your Insurance Cards

2 INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured	☐ Child ☐ Other	☐ Child ☐ Other
Complete the following Insured information if *RELATION* is other than *SELF*		
Insured's Name:		
Insured's Birth Date:		
Male or Female		
Complete the following Insured information if it differs from the Patient's		
Insured's Address:		
City, State, Zip:		
Phone Number:	( )	( )

3 ACCIDENT INFORMATION (If Patient condition is due to an accident/injury)

CLAIM FILING INFORMATION	
Accident type:	☐ Auto Accident ☐ Personal Injury
Date of injury/accident	
Insurance Carrier Name:	
Carrier Address:	
City, State, Zip	
Adjuster's Name	
Adjuster's Phone Number:	( )
Claim Number:	

I, the undersigned, hereby authorize the staff to perform such services as necessary by the chiropractic physician to diagnose and treat my condition(s) Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. Additionally, I authorize this office to release any and all of my medical records as deemed necessary. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient/Parent Signature: _____ **Date:** _____