

Welcome Sheet for Children

Personal Information

Accident Information

Child's Information:

Patient Name: _____

Address: _____

City/State/Zip: _____

Birth date: ____ / ____ / ____ Age: ____ Gender: ____

Parent or Legal Guardian's Information:

Name: _____

Address: _____

City/State/Zip: _____

Birth date: ____ / ____ / ____ Age: ____ Gender: ____

SSN#: ____ - ____ - ____ Employer Name: _____

Occupation: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Would you like to receive automated text message or email reminders for your child's appointments? Yes No

Cell phone carrier for text reminders: _____

Whom may we thank for referring you to us?

Patient/Friend/Family _____

Physician/Specialist Office Event /Health Fair

Office Sign/Banner Website/Other Advertisement

Other: _____

I certify that the information I have completed above is accurate and true to the best of my knowledge

X _____
Parent's / Guardian's Signature Date

Is condition due to an accident? Y N Date: ____ / ____ / ____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Work Comp Other

Notice of Privacy Practices (HIPPA)

I understand and have been provided with a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

X _____
Parent's / Guardian's Signature Date

Assignment and Release

I certify that I have insurance coverage with: _____
Name of Insurance Company(ies)

and assign directly to **Walker Road Chiropractic** 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 authorize the use of my signature on all insurance submissions.

Walker Road Chiropractic may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when I submit written notice to Walker Road Chiropractic.

X _____
Parent's / Guardian's Signature Date

Parent or Legal Guardian - Photo ID

Due to the increased cases of identity theft our office will require a copy of your photo ID to verify your identity

Acknowledgement & Agreement

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that pain syndromes can be caused by conditions (such as tumors, etc.), which may be visualized by x-rays. Should the doctor deem x-rays are not necessary for my child's condition, I agree not to hold anyone associated with this clinic responsible for such pathology. I authorize the release of any medical information necessary to process this claim.

X _____
Parent's / Guardian's Signature Date