APPLICATION FOR TREATMENT-CHILDREN

NAME: _____ NICK NAME: _____

ADDRESS: _____ HOME PHONE: _____

CITY/STATE/ZIP: _____

DATE OF BIRTH: _____ AGE: _____

SCHOOL: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

MOTHER: _____ CELL PHONE: _____

FATHER: _____ CELL PHONE: _____

PERSON TO CONTACT IN CASE OF EMERGENCY? _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____

NAME OF CARDHOLDER: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

Welcome to the Family Tree Chiropractic & Wellness. Our entire office is dedicated to providing you with the best health care possible.

We request payment at the time services are rendered. You may pay by cash, check, Mastercard, Visa, or Discover.

If you are unable to keep your appointment time, we require that a 24-hour notice be given as a courtesy to the doctor. ***If a 24-hour notice is not given, we reserve the right to charge for the office visit appointment.***

Parents have read and understand the above policies.

PARENT SIGNATURE: _____

PATIENT NAME: _____ DATE: _____

CHART #: _____

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