692 W. Schuylkill Road • Pottstown, PA
Phone: 484.624.3726
www.infinity-chiropractic.com

PATIENT INFORMATION - CHILD

Child's Name:_____

Address:_____City:_____State:_____Zip:_____

Age:_____ Gender: ☐Female ☐Male Birthdate:_____ Parent's SS#_____

Email Address:_____

(This may be used for future newletter mailings or massage specials! It will not be solicited)

Mother's name:_____Father's name_____

Home Phone:_____Cell Phone:_____ Work Phone: _____

Insured's Name:_____Insured's DOB:_____

Insured's Employer:_____Occupation:_____

Employer's address:_____

Emergency Contact:_____Phone:_____

(Other than someone you live with)

How did you hear about our office? (Please list specific provider, media source, yellow pages, etc.) _____

Primary Health Care Practitioner and/or Clinic:_____
Address:_____Phone:_____

Note: The Front desk may have you sign a Patient Authorization to Release Information form, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

AUTHORIZATION FOR CARE OF MINOR

Parent/Guardian's signature_____Date_____