

Welcome to Schroeder Chiropractic

Pediatric Intake Form

Who may we thank for referring you? _____

First Name: _____ Last Name _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Birth date: _____ Grade in School: _____

School: _____ Activity: _____

Name of Guardian #1: _____ Relationship: _____

Contact Number: _____

Name of Guardian #2: _____ Relationship: _____

Contact Number: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Who is responsible for this account: _____ Relationship to Patient: _____

Insurance Coverage Available? YES NO Does Not Cover Chiropractic Care Not Sure

Do you have a PCA, FSA, HRA, or HSA account associated with your insurance carrier(s)?

- If you do, the funds reserved in that account will be used for services rendered at our office. Your insurance company determines the amount submitted to your savings plan. We are unable to refund payments directly to the patient.

Insurance Company: _____

Please Provide Copy of Card

I, the undersigned certify that I (or my dependent) have insurance coverage with the above company and assign directly to Schroeder Chiropractic PC 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 or use of my PCA, FSA, HRA, or HSA plan. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and I authorize the use of the signature on all insurance submissions.

I consent to treatment, understanding that risks are present with any treatments and that treatment is my choice.

Guardian Signature

Printed Name