



Child (under 18 years of age) Information & Consent Form

Child's Full Name: _____ Date of Birth: __/__/__

Social Security #: _____ Parent/Guardian Name(s) _____

Address: _____ City: _____

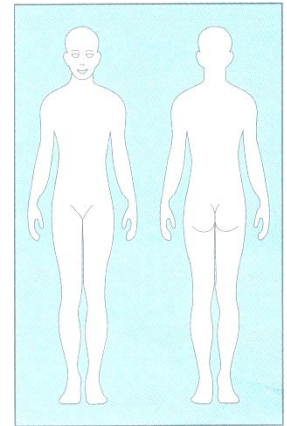
State: _____ Zip: _____ Phone Number: _____

Health Problem or visit reason? _____

When did the symptoms/ issues appear? _____

Is this condition getting progressively worse? Yes No Unknown

If applicable please mark the body with the symbol X where problems/pains are being experienced.



Was the birth normal? Yes/No If No why? _____

Is there any medication(s) the child is on? Yes /No If yes, what? _____

Has the Child had any surgeries? Yes/No If yes when and where? _____

Additional Comments: _____

I hereby authorize an office evaluation, examination and x-rays to be performed on my child and certify that I have the legal guardianship to make health decisions on behalf of this child. I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Parent Name: _____

Signature: _____ Date: _____