ABOUT YOU

Child Information

Today's Date________/________/________

Name:____

Nickname:____________________________________ ☐ Male ☐ Female

Birthdate: _______/_______/_______ Age:________________ SS#:________________________

Home Address:____

____
City State Zip

Referred By:____

How did you hear about us: ☐ Radio ☐ Newspaper ☐ Advertisement ______________ ☐ Other ______________

Pediatrician's / Primary Care Physician's Name: ________________________________

Parent / Guardian Information

Name:______________________________ E-mail Address:______________________

Relation: ☐ Mother ☐ Father ☐ Grandparent ☐ Other: ______________________

Birthdate: _______/_______/_______ Age:__________ SS#:________________________

Home Address:__City__________State__________Zip__________

____

Home Phone#:________________________ Cell Phone:________________________

Occupation:________________________ Work Phone: ________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

MASSAGE PATIENTS ONLY (please read the following and sign)

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, or for increasing circulation and energy flow. If I experience any pain or discomfort during this massage session, I will immediately inform the massage therapist.

I understand that the massage therapist does not diagnose disease, illness or any other physical or mental disorders. Also, the massage therapist neither prescribes medical treatment or pharmaceuticals, nor do they perform spinal manipulations.

I have disclosed all health information truthfully and in full.

Parent / Guardian Signature: ______________________________ Date______________

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. / I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

I read and understand the HIPPA Compliance.

I read and understand the Consent to Treat a Minor.

Signature________________________________ Date_______ /_______ /_______