Please complete the following information:

Name _____ **Date of Birth** _____

SS# _____ **Wt**_____ **HT**_____

Address _____ **Phone** _____

City Zip

Parent or Guardian _____

Address _____ Phone _____

City Zip

List any medications currently taking _____

Does your child ever complain of the following:

____ *Headaches*
____ *Dizziness*
____ *Ringing in the ears*
____ *Chronic stomach aches*
____ *Pain and aches in legs/arms*
____ *Sore throats*
____ *Ear Aches*
____ *Allergies*
____ *Back Pain*
____ *Blurred vision*

Any additional information _____
_____

Name of person responsible for payment _____

Are you insured: **yes** **no** (please circle) Company Name_____

I hereby authorize Dr. Doyle and whomever she may designate as assistants to administer chiropractic care as deemed necessary to my _____(indicate relationship of child),

Dated at _____ this _____ day of _____, 19_____.

(City)

Signed _____ Witnessed _____

I understand that payment is required at the time of service. Most medical insurance and some credit cards are accepted. In this event, I understand and agree that the chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and I authorize direct payment directly to this chiropractic office. However, I clearly understand that all services rendered on the above named patient are directly charged to me and that I am personally responsible for payment. Should there be a default in the above agreement, I agree to pay all collection agency fees, attorney fees, court fees, and other related costs incurred in the collection of this account.

Parent Signature _____ Date _____