

Minor Non-Pl

537 West Sugar Creek Road, Suite 101 Charlotte, North Carolina 28213

Dr. Henry E. Rice Dr. Ferzaan A. Ali Dr. R. Scott Saario

Date: _____

Date:

New Patient Information/Patient Information Update (Please PRINT Clearly)

			• /	
Date:/				Chart #:
Name:First	Middle		Last	
				Apartment #:
				r's License #:
•				·
Home Phone: ()				
DOB:/				
School:				
				SN:
				OOB:/
D	.9 V	Na atawa Niama		
				provide a copy of your insurance card)
-				
What is the approximate da	ite that this injury o	r flair up begai	1?	
Nearest Friend or relative t	hat can be contacted	d in case of an	emergency:	
Relationship:		F	Phone #: (
It is usual and	customary to pay	for services as	rendered unl	ess otherwise arranged.
•	with a full report of	physical exami	•	D.C./R. Scott Saario, D.C.) to sis, treatment, prognosis, etc. of
chiropractic service rendere	ed me. <u>I understand</u> service rendered me	I am directly a	and fully respor	nay be due on owing him for nsible to said doctor for all medical ely for said doctor's additional
insurance company does no	ot cooperate in protection and payable; the	ecting said doc	tor's interest, h	e. I have also been advised that if my e will not await payment but may of exceed amounts due and payable

Patient's Signature:

Parent's Signature: ____



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Have you ever had chiropractic car	re before?
Yes:	If Yes, where?
No:	
How did you hear about our praction	ce? (Please be specific)
Relative	
Friend	
Doctor	
Sign	
Billboard	
Yellow Pages	
Other	
In reference to your child's health insurance	ce: (please choose one and initial on the line)
My child has health insurance a	nd I wish to have it filed if it includes chiropractic coverage.
My child does not have health in	surance.
My child has health insurance by pay for each visit at time of ser	at choose <u>not to have it filed</u> for this injury/illness. You will need to vice.
•••••	•••••••
**	'HIPAA Notice of Privacy Practices" made available to me. I am with me and may return to get a copy at any time.
Patient's Signature:	Date:
Parent's Signature:	Date:
	SENT TO TREAT A MINOR
Name of Minor:	Date of Birth:
hereby authorize ChiroCarolina to administer a received treatment at your practice previous to to the treatment mentioned above. I further au which are customarily completed and signed b	al parent or legal guardian of the above-referenced minor ("the minor"), and as it so deems necessary to the minor. In the event that the minor has the date of this consent form, I hereby authorize such treatment in addition thorize the minor to complete and sign any documents at ChiroCarolina y patients at your practice as a condition to treatment, and such signatures gnature to any other such document have any effect on this consent form.
Full Name of Parent/Legal Guardian (pleas	e print clearly):
Relationship to Minor: (circle one) Parent / Ad	loptive parent with custody / Legal Guardian / Other (specify):
SSN of Parent/Guardian:	D.O.B. of Parent/Guardian:
	Phone: ()
	Date: