5124 Western Ave S Suite 1
Sioux Falls, SD 57108

PATIENT INFORMATION

Child's Name:____

Address:_________________________City:_______________State:_________Zip:_______

Age:_______ Gender: □ Female □ Male Birthdate:__________ Parent's SS#__________

Email Address:____

(This may be used for future newletter mailings or massage specials! It will not be solicited)

Mother's name:_______________________Father's name____________________________

Home Phone:________________Cell Phone:______________ Work Phone: ______________

Insured's Name:___________________________________Insured's DOB:____________

Insured's Employer:___________________________Occupation:______________________

Employer's address:____

Emergency Contact:_______________________Phone:_____________________________

(Other than someone you live with)

How did you hear about our office? (Please list specific provider, media source, yellow pages, etc.) ____

Primary Health Care Practitioner and/or Clinic:__________________________________
Address:________________________________Phone:_____________________________

Note: The Front desk may have you sign a Patient Authorization to Release Information form, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

AUTHORIZATION FOR CARE OF MINOR

Parent/Guardian's signature________________________________Date________________