



1426 New Schuylkill Road • Pottstown, PA  
Phone: 484.624.3726  
www.infinity-chiropractic.com

**PATIENT INFORMATION - CHILD**

Child's Name: \_\_\_\_\_ Text

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Gender:  Female  Male Birthdate: \_\_\_\_\_ Parent's SS# \_\_\_\_\_

Email Address: \_\_\_\_\_

**(This may be used for future newsletter 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 \_\_\_\_\_