

PATIENT INFORMATION FOR MEDICAL RECORDS

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Date: _____

Patient _____ Sex: M F
Last Name First Name M.I.
Birthdate _____ Marital Status- S M D Sep W Referred by _____
Driver's License #- _____ Social Security #- _____
E-Mail _____ Cell Phone _____
Home Address _____ Home Phone _____
City _____ Zip _____ Occupation _____
Employer _____ Work Phone _____
Address _____ City _____ Zip _____

Parent (if minor) / Spouse _____ Relation _____
Social Security # _____ Birthdate _____
Employed by _____ Work Phone _____
Address _____ City _____ Zip _____

Emergency Contact (Name) _____ Relation _____
Address _____ City _____ Phone (W) _____ (H) _____

INFORMED CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. _____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests including, but not limited to radiographs, range of motion, orthopedic and neurological testing and to administer treatment as is appropriate. Such treatment may include but not be limited to spinal manipulative therapy, soft tissue therapy, exercise therapy and physiological therapeutic procedures including, but not limited to, ultrasound and electrical muscle stimulation. All health care procedures have some inherent risk and the significant risks associated with chiropractic care are estimated to occur between one in one million to one in five million treatments. I have reviewed these risks and have decided to undergo treatment with this doctor.

Patient's signature _____ Date _____

The above informed consent information has been discussed with the patient by _____ on _____
DOCTOR DATE

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize _____ D.C. and whomever he/she may designate as his/her assistant(s). To perform diagnostic tests, including but not limited to radiographs and to administer treatment as he/she deems necessary to my son/daughter, (name) _____

Parent/Guardian signature _____ Date _____