

FAMILY HEALTH HISTORY (MOTHER, FATHER, SISTER, BROTHER) PLEASE CIRCLE:

ARTHRITIS CANCER DIABETES HEART DISEASE BACK PROBLEMS STROKE

DO YOU SMOKE Y or N _____ PKS/DAY _____ YEARS DO YOU USE ALCOHOL _____

FOR WOMEN ONLY:

ARE YOU PREGNANT _____ DUE DATE _____ ARE YOU NURSING _____

ARE YOU TAKING BIRTH CONTROL _____ 1ST DATE OF LAST CYCLE _____

INFORMED CONSENT TO TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me or on the patient named below for whom I am legally responsible for by the Doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below, or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel regarding the nature and purpose of chiropractic adjustments and procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do expect the doctor to exercise judgement during the course of the procedure which the doctor feels, at the time, based upon the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to discuss or ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any conditions in the future for which I seek treatment.

SIGNATURE DATE

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE: DATE:

By my initials _____, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance unpaid by the insurance company.

*Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements are made with the office manager. **How will you be paying for today's visit?** _____ CASH _____ CHECK _____ CREDIT CARD _____ GIFT CERT _____ ACCIDENT