

WELCOME TO OUR OFFICE

Name _____ Referred by _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Home Phone _____ Work _____ Cell _____

Authorization to contact you by e-mail when necessary Yes No

Sex Male Female Age _____ Birthdate _____

Occupation _____ Single Married Widowed Divorced

Emergency Contact _____ Phone _____

Today's office visit is related to: Auto Accident Workers Compensation Neither

How would you rate your overall health? Excellent Very Good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Previous surgeries / illnesses _____

Previous auto accidents / traumas _____

Date of last spinal: X-ray _____ MRI _____ CT Scan _____

Date of last Chiropractic Appointment _____ Never have been to a Chiropractor

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures and therapies on me (or on the patient named above, for I am legally responsible) by Cunha Family Chiropractic, LLC.

Alternatives to Chiropractic treatment include, but are not limited to, medical evaluation and treatment. Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and I am informed that there are some risks to treatment.

I have had the opportunity to discuss with the office personnel the purpose and benefits, possible risks, and alternatives to Chiropractic treatment. _____ (please initial)

ASSIGNMENT AND RELEASE

I assign directly to Cunha Family Chiropractic, LLC all chiropractic benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Patient Signature (or Legal Guardian)

Date