PATIENT CONSENT FORM



| First Name: | | Last Name: | | | | | |
|---|------------------|--------------|-----------|---------------|--|--|--|
| Address: | | | | | | | |
| City: | | St: | Zip Code: | | | | |
| Date of Birth: | | | | | | | |
| Home Tel: | | Cell No: | | | | | |
| E-Mail Address: | | | | | | | |
| Gender: Male Female | | | | | | | |
| Please Tell Us How You Heard About Us: | | | | | | | |
| Referral D by Name: | | | | | | | |
| Internet | Newspaper Advert | Yellow Pages | , 🗆 | Spinal Screen | | | |
| Walk In | Patient Program | Unknown 🗆 | | Other | | | |
| Declarations: | | | | | | | |
| I will be claiming on my Medical Insurance. Yes \square No \square Not Sure \square | | | | | | | |
| I have read the HIPPA form & understand that it's available to me at any time. | | | | | | | |
| I understand that the clinic will store my personal information in their database. | | | | | | | |
| Patient Signature: X | | Date: | x | | | | |

CONSENT TO EXAMINATION & X-Ray:

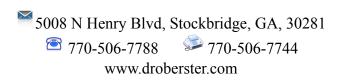
I consent to an appropriate Chiropractic physical examination.

I confirm that there is no possibility of pregnancy.

I have been informed of the need for an appropriate X-Ray examination & consent to this procedure.

I/We understand that all X-Ray films taken are the property of Oberster Chiropractic.

If I /we need to borrow or copy the X-rays from Oberster Chiropractic, I understand that I will be required to sign a release form & will be charged \$15 admin fee, X-Rays will be in CD format.





| Patient Signature: | X | Date: X | | | | |
|--|---|-------------------|------|--|--|--|
| If you are under 18 years of age, this consent must be signed by a parent or legal guardian. | | | | | | |
| Signed: | | (Parent/Guardian) | Date | | | |
| | | | | | | |
| CONSENT TO REPORT OF FINDINGS AND TREATMENT: | | | | | | |
| I have been given a verbal Report of Findings regarding my condition. I have been advised of, and understand the benefits and risks of treatment. I have had all of my questions answered to my satisfaction. I agree to treatment in the following areas Neck, Upper Back, Lower Back & Other. I consent to Chiropractic treatment as outlined to me. | | | | | | |
| Patient Signature: | X | Date: X | | | | |
| If you are under 18 years of age, this consent should be signed by a parent or legal guardian. | | | | | | |
| Signed: | | (Parent/Guardian) | Date | | | |