

WELCOME

PATIENT INFORMATION

Please Print Please allow our staff to photocopy your insurance card and all available insurance information.

FULL NAME _____	GENDER: M F	HOME PHONE _____
ADDRESS _____	CITY, STATE, ZIP _____	
WORK PHONE _____	CELL PHONE _____	E-MAIL _____
AGE _____	DATE OF BIRTH ___/___/___	MARITAL STATUS: S M W D Sep NO. of Children _____
SS# _____	Driver's License # _____	State of License _____

Your Employer _____	Your Occupation _____	Years on Job _____
Employer Address _____	City, State, Zip _____	
Work Phone _____		

Name of Spouse, Parent or Guardian _____	Age _____	Date of Birth ___/___/___
Spouse/Parent Employer _____	Spouse/Parent Occupation _____	SS# _____
Employer's Address _____	City, State, Zip _____	
Work Phone _____		

EMERGENCY CONTACT INFORMATION		
Name _____	Relationship to you _____	Phone Number _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

DESCRIBE THE MAJOR COMPLAINTS THAT BRING YOU TO OUR OFFICE: _____

IS THIS A WORK RELATED INJURY, CAR ACCIDENT OR FALL? YES NO
DATE OF ACCIDENT _____ CLAIM # _____
INSURANCE COMPANY _____ PHONE NUMBER _____

Payment Options (Please Indicate): Cash Check MasterCard Visa

Would you like to receive educational e-mails from our office? Yes No

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photocopy of this agreement shall serve as the original.

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

Patient's Signature _____ Date _____

Spouse/Guardian's Signature _____ Date _____

Consent for treatment

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical table upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: which will be prescribed and performed as indicated by the doctor.

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	ultrasound
hot/cold therapy	EMS (electric muscle stimulation)	
radiographic studies	stretching	deep tissue massage
algometric/pressure testing		
Other (please explain) _____		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindication to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The nature of Acupuncture

Acupuncture involves the insertion of very fine needles in various locations on the body. Acupuncture has been shown to have an effect on circulation, blood pressure, production of blood cells, and release of hormones that help the body respond to injury and stress. Complications from acupuncture may include:

- a. **Bleeding and Bruising** – As with acupuncture in general, when a needle is removed some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally a

bruise or hematoma may appear. Topical and internal remedies will be discussed to address bruising. If swelling persists, call me immediately.

- b. **Infection** – Infection at the needle site is very rare after an acupuncture treatment because the needles are sterile. If you suspect infection at the needling site (i.e. Redness, swelling or warm to the touch) call me immediately. Additional treatment or referral to your General Practitioner may be necessary.
- c. **Needle Shock** – Needle shock is a rare complication that can happen during any acupuncture treatment. If you feel faint or shaky during treatment, please let me know immediately.

Allergic Reaction – In rare cases, local allergies to topical preparations have been reported. Systemic reactions that are more serious may occur to herbs used during treatment. Skin testing is done prior to application of any herbal preparations. Allergic reactions may require additional treatment or discontinuation of treatment

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:

I have read [] or have read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jeffrey Wong and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian
(if a minor)