

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 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 No Not Sure

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.

 5008 N Henry Blvd, Stockbridge, GA, 30281

 770-506-7788  770-506-7744

www.droberster.com



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 _____

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