CONFIDENTIAL PATIENT HEALTH RECORD

WELCOME The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care, a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this form, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/A for nonapplicable.

Personal Information

Name *(First, Middle, Last)* _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

SSN _____ Gender *(Circle)* M / F Email _____

Home Phone _____ Cell Phone _____ Best Place to Call? *(Circle)* Home Cell Work

Spouse _____ Marital Status *(Circle)* Divorced Married Single Separated Widowed

Names & Ages of Children _____

Employer

Business Name _____ Occupation/Job Title _____

Business Address _____ Business Phone _____

Emergency Contact Information

Name *(First, Middle, Last)* _____ Relationship _____

Address _____ Contact Phone _____

Primary Care Physician: _____ Physician Phone _____

Insurance Information

Personal Health Insurance Carrier _____ ID # _____

Insured Person's Name _____ Group # _____

Insured Person's Date of Birth _____ Insured Person's SSN _____

Referral Information

How did you hear about our clinic or whom may we thank for referring you? _____

DISCLOSURE AND CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. 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 the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below. I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACCEPTANCE AS A PATIENT I understand and agree that Dr. Donald L. Aivalotis, II has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature _____ **Date** _____