PATIENT INFORMATION & CONSENT

(PLEASE PRINT)

PATIENT NAME: LAST FIRST MIDDLE					SEX	DATE OF BIRTH
HAVE WE SEEN ANYONE ELSE IN THE FAMILY? Y N NAME:			HOW DID YOU HEAR ABOUT US?			
HOME ADDRESS (include appt. # if applicable)			CITY		STATE	ZIP
EMAIL		MARITAL STATUS	CELL PHONE	HOME PHONE		
EMPLOYER		OCCUPATION		EMPLOYER PHONE		
RESPONSIBLE PARTY NAME SAME AS ABOVE? Y N		RELATIONSHIP TO PATIENT				
RESPONSIBLE PARTY ADDRESS			CITY		STATE	ZIP
RESPONSIBLE PARTY EMPLOYER			WORK PHONE	CELL PHONE		
SPOUSE NAME	DATE OF BIRTH	EMPLOYER		PHONE		
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	CELL/HOME PHONE		WORK PHONE		

ABOUT CHIROPRACTIC

We want to improve your health by maximizing your body's natural healing abilities. Chiropractic care as practiced in this office is about restoring balance and harmony to the body. Dr. Carlow will achieve this by locating spinal misalignments, joint restrictions, muscular imbalance and weakness and working to correct these problems. Dr. Carlow will utilize his hands or mechanical devices to adjust the misaligned vertebrae thereby restoring more normal joint motion. Therapy such as massage, myofascial therapy, electric stimulation, cold laser, disc decompression, traction, stretching and exercise may also be used to help you heal more quickly.

AUTHORIZATION AND CONSENT FOR HEALTH CARE

I hereby authorize Daniel J. Carlow, D.C, P.C./DBA Islands Chiropractic and affiliated providers of service involved in my care to release any information acquired in the course of my treatment as may be necessary to the following parties: my insurance company, my employer, my immediate family, my legal guardian or my third party payer as may be required for claims filed, quality assurance, health plan administration, complaints or grievances. I understand the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses. I acknowledge I have been provided a copy of the Notice of Privacy Practices.

I understand if accepted as a patient I will be relying on Dr. Carlow to make his best judgment using his knowledge and clinical experience to render a diagnosis and treatment plan for me. I understand and am informed that there are inherent risks to any type of healthcare treatment including chiropractic care and that there are no guarantees of a cure. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by Daniel J. Carlow, D.C, his associates, assistants, or other healthcare providers he believes necessary to help resolve my condition.

I certify I have read and understand this Authorization and Consent For Health Care.

_____ _____

Signature of Patient, Parent, Guardian or Responsible Party Date