

PATIENT INFORMATION & CONSENT
(PLEASE PRINT RESPONSES)

NAME		SEX	DATE OF BIRTH
HOME ADDRESS	CITY	STATE	ZIP
PHONE	EMAIL		
EMPLOYER	OCCUPATION		
SPOUSE NAME	PHONE		
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE	
HOW DID YOU HEAR ABOUT ISLANDS CHIROPRACTIC / DR. CARLOW?			
HEALTH INS CO. AND PHONE	ID	GROUP	

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 achieve a more optimal response.

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.

Please check here if you would like to receive our newsletter and other in-office special notices

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

Signature of Patient, Parent, Guardian or Responsible Party

Date