Patient Information

Patient Name:____

Address:____

City:____________________ State:__________ ZIP:__________

Phone:_________________ Email:________________________

Sex: M F Age:________ Birthday:____________________

Married Single Widowed Separated Divorced Partnered Minor

In Case of Emergency:

Contact Name:____________________________

Relationship:____________________________

Phone:________________________________

How did you find us?______________________________

HOW CAN WE HELP YOU?

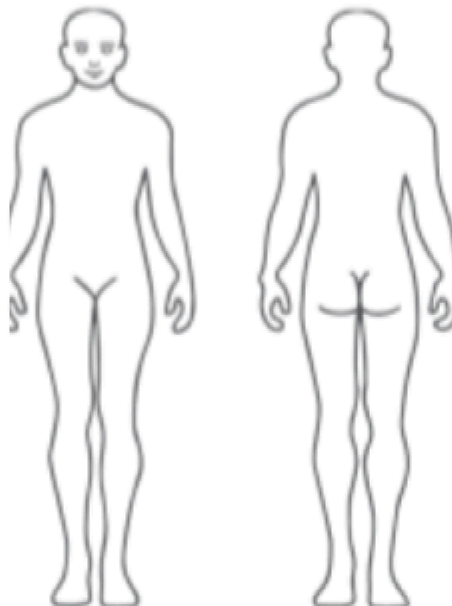
What brings you in today?____________________________________

What symptoms are you experiencing?______________________________

How intense are your symptoms? (circle one) 0 1 2 3 4 5 6 7 8 9 10

No Intense

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (circle where appropriate)

Numbness	Sharp
Tingling	Shooting
Stiffness	Burning
Dull	Throbbing
Aching	Stabbing
Cramping	Swelling

Other ____________________

MEDICAL HISTORY

Please list any conditions or medications you want us to be aware of:

X-Ray Consent

Patient Name:__________________________

Date of Birth:___________________________

I authorize the performance of a diagnostic x-ray examination of myself which Willow Bend Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signature:______________________________

Date:__________________________________

If the patient is a Minor:

I am the parent or legal representative of ____________________ who is a minor, _____ years of age. I authorize the performance of a diagnostic x-ray of this minor which Willow Bend Chiropractic may consider necessary or advisable.

Signature:____________________________ Parent Name: _________________________________

Date:__________________________________

Females:

REGARDING THE POSSIBILITY OF PREGNANCY: This is to certify that, to the best of my knowledge, I am not pregnant, and Willow Bend Chiropractic has my permission to perform a diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signature:_______________________________

Date:__________________________________

1532 N Dove Ln, Suite 202
St. George, UT 84790
PH (435) 673-0900 FX (435) 359-5102

Consent for Treatment at Willow Bend Chiropractic

The Nature of Chiropractic Treatment: The Doctors of Chiropractic will use their hands or mechanical devices in order to move your joints. You may feel a “click” or “pop” such as the noise when a knuckle is “cracked” and you may feel the movement of the joint. Another treatment the doctor may recommend is cervical or lumbar decompression. Spinal decompression works by gently stretching the spine. This helps take pressure off of the discs between the bones in your spine. Various ancillary procedures, such as hot or cold packs and electric muscle stimulation may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include but are not limited to, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck, which could lead to nerve damage or death. A minority of patients may notice stiffness or soreness after the first few days of treatment. The possible side effects of spinal decompression include but are not limited to recurrent or continuing symptoms, blood clots, dural tear, leakage of cerebrospinal fluid, nerve injury and/or paralysis, and death. The ancillary procedures could produce skin irritation, burns or minor complications. Inform the doctor if you have a pacemaker.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

***** PLEASE CONTINUE TO THE NEXT SIDE AND SIGN! *****

Insurance Notice: I authorize my healthcare provider to collect, use, and disclose my personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the purpose of assessing my claims and administering the benefits of my plan. I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided. Willow Bend Chiropractic will do its best to assess my insurance eligibility and insurance benefits. I understand it ultimately remains my responsibility to understand my benefits if I opt to use my insurance plan for chiropractic care.

Cancellation Policy: Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the Practitioner's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file, up to 50% of the appointment charge.

I have read the explanation above of chiropractic treatment, spinal decompression, and possible side effects. If I have any further questions or concerns, I will consult the doctor. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment(s), and hereby give my full consent to treatment. I also understand the clinic cancellation policy and use of my personal information if I choose to have the clinic bill my health insurance and give my full consent.

PATIENT OR PARENT SIGNATURE:_______________________________________ DATE:____________________

NAME:____PHONE:________________DOB:______________

EMAIL: ____

ADDRESS:____

CITY:_______________________________________STATE:___________________ZIP:______________________

________I consent to receive email and text messages with office communications.