BREWER CHIROPRACTIC

Patient Information: _____ Date: _____

First Name: _____ **Middle Initial**: _____ **Last Name**: _____

Address Line 1:_____

Address Line 2:_____

City:_____ **State**: _____ **Zip Code**: _____

Home Phone: (____)_____-_____ **Work Phone**: (____)_____-_____

Cell Phone: (____)_____-_____ **Email**:_____

Date of Birth: ____/____/_____ **Marital Status:** □ Single □ Married □ Other

Social Security Number: _____-____-_____

Employment Status: □ Employed □ Full-Time Student □ Part-Time Student □ Other

Spouse Data (Only needed if using insurance that is under your spouse's name)

Name: _____ **Contact Number**: _____

Date of Birth: _____ **Social Security Number:** _____-_____-_____

Employer Data (Please enter spouse's employer if using their insurance)

Name: _____

Address Line: _____

City: _____ **State**: _____ **Zip Code**: _____

Emergency Contact _____

Contact Name:_____ **Contact Number**:_____

How did you hear about us? _____

CONSENT TO TREATMENT WITHOUT X-RAYS

I hereby authorize Brewer Chiropractic/Dr. Brewer and whomever he may designate as his assistants to administer treatment to me as he deems necessary. I give consent for this treatment without receiving chiropractic X-rays. I agree to follow his treatment plan recommendations and will give at least a 24 hour notice of cancellation of any scheduled appointments.

Patient Signature _____ Date ____/____/____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA Rules)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practice. I understand that this form will be placed in my patient file and maintained for six years.

Patient signature_____ Date____/____/____

AUTHORIZATION FOR APPOINTMENT REMINDERS AND MAILINGS

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, and advise you about health related meetings, workshops. If you choose not to authorize this information your decision will have no adverse effect on your care from Brewer Chiropractic.

Your signature indicates your authorization_____

ACKNOWLEDGMENT OF PREGNANCY (Females Only)

I hereby acknowledge that: _____I **am** pregnant _____I am **not** pregnant
I authorize Dr. Brewer/Brewer Chiropractic and whomever he designates as
his assistants to administer treatment as he deems necessary in light of this information.
Patient Signature_____ Date____/____/____

CONSENT TO TREATMENT OF A MINOR

I hereby authorize Dr. Brewer/Brewer Chiropractic and whomever he may
designate as his assistants to administer treatment as he deems necessary to my daughter/son.
Patient name_____
Signature of parent/guardian_____Date___/____/____

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Witness Signature

_____

Date

BREWER CHIROPRACTIC

By law we are required to update our Electronic Health Records, please fill this out to the best of your ability.

Name_____**Date**_____

Race (check one)

□ White □ Hispanic □ Black/African American □ American Indian □ Other

Ethnicity (check one)

□ Not Hispanic or Latino □ Hispanic or Latino □ I choose not to specify

Smoking Status? □ Current Smoker □ Former Smoker □ Never been a smoker

What is your height and weight? _____Height _____Weight

Do you have?

□ Diabetes □ High Blood Pressure □ High Cholesterol □ Other _____

Current Medications (please include dosage if known) □ **NONE**

1._____ 4._____

2._____ 5._____

3._____ 6._____

List any known allergies to medications □ **NONE**

1._____ 2._____

Brewer Chiropractic is required to provide you with electronic access to your health records. Please provide your email address and answer the security question below.

_____ What is your favorite color?_____

Email Address