CHAPP
CHIROPRACTIC

New Patient Application

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____

State_____ Zip_____

Phone:

Cell_____Home_____Work_____

Email _____

Occupation_____ Employer's Name_____

Status: Single / Married / Divorced / Widowed

Spouse's Name_____

Number of Children_____

Do you have health insurance YES/NO

If YES for health insurance please provide carrier name(s) _____

Please note you will have to provide your insurance card(s) both front and back along with a Driver's License at time of service

Emergency contact name/phone #:_____

Relationship: _____

Who may we thank for referring you?

_____

****Please Complete Both Sides****

9090 S Rodgers CT SE, Suite B., Caledonia, MI 49316

616-698-6981 contact@chappchiropractic.com

CHAPP
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Informed Consent for Care

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 on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office of Chapp Chiropractic, PLLC.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel at Chapp Chiropractic, PLLC the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Signature_____Date _____

Print Patient Name_____

Legal Guardian Signature_____Date_____

****Please Complete Both Sides****

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