Today's Date: _____
First Name:_____
Middle Initial:_____
Last Name:_____
Nickname:_____
Address:_____
City:_____
State:_____ Zip:_____
Social Security #:_____
Gender: □Male □Female
Marital Status: S M D W
Your Date of Birth:_____Age___
Home Phone:_____
Work Phone: _____Ext:_____
Cell Phone:_____
Cell Phone Carrier:_____
Primary Contact:
□Cell □Home □Work □Text
Secondary Contact:
□Cell □Home □Work □Text
Email:_____

Referred By:_____

Your occupation:_____
Employer:_____
Employer Address:_____
Employed □Full Time □Part Time □Other

Is your current condition or symptom, due to an auto or work related injury?
□No □Yes-Auto □Yes-Work □Maybe

Do you have health insurance?
□Yes □No

Insurance Company
Name:_____
Policy ID #:_____
Group#:_____
Policy Holder
Name:_____
Date of Birth:_____
What is your relationship to the policy holder? □Self □Spouse □Child

Do you have a secondary/ another insurance?
□Yes □No
Other Insurance Company
Name:_____
Policy ID #:_____
Group#:_____
Policy Holder
Name:_____
Date of Birth:_____
What is your relationship to the policy holder? □Self □Spouse □Child

Responsible Party & Emergency Contact
Name: _____
SS#:_____Work Ph#:_____
Employer_____
Employer's Address _____
Name of Spouse _____
Spouse's Employer_____
Spouse's Work Ph#:_____

Primary Care Physician
Name:_____
Phone:_____
Address:_____
Last Visit:_____

Other doctor(s) seen for this condition, prior to your first visit to this office.
1. Dr. _____
First visit date: _____
Specialty_____
X-rays done? □Yes □No
Types of treatments received:_____
_____
How many treatments received? _____
Currently treating? □Yes □No
Did treatments benefit you? □Yes □No
Last visit date: _____

Other doctor(s) seen for this condition, prior to your first visit to this office.

2.Dr. _____
First visit date: _____
Specialty_____
X-rays done? □Yes □No
Types of treatments received:_____

How many treatments received?
Currently treating? □Yes □No
Did treatments benefit you? □Yes □No
Last visit date:_____

Have you been treated for any other health condition by a physician in the last year?
□Yes, describe:_____
_____
□No

List all surgeries you've had and when:
_____
_____

What medications do you take?_____
_____
_____

Is there any other information that you want to give your Doctor?
_____
_____

Your Dominant Hand:
□**Right** □**Left** □**Both**

Please read and initial each of the following:

_____**FINANCIAL ARRANGEMENTS:** I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care, as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office.

_____**ASSIGNMENT OF BENEFITS:** I authorize direct payment of medical benefits to this office and release of medical information necessary to process my insurance claims.

_____**APPOINTMENT CANCELATION:** I understand that Dopps on West Central charges $20, if they are not notified of appointment cancellation, prior to scheduled appointment time.

_____**NOTICE OF PRIVACY PRACTICES:** I certify that I have received a complete copy of Dopps' Notice of Privacy Practices. By signing this form, you are granting consent to Dopps to use and disclose your protected information for the purposes of treatment, payment and health care operations. We encourage you to read the Notice of Privacy Practices, in full. Please include any person(s) authorized for your patient information to be released to:

Name:_____
Address:_____
Phone:_____

Parent/ Guardian Signature:

_____

Today's Date:_____

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries of complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

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

Dated this _____ day of _____, 20_____.

_____ _____

Patient Name Patient Signature (or Legal Guardian)

_____ _____

Witness Name Signature of Witness

Dopps Chiropractic
6820 W Central
Wichita, Ks 67212
(316) 722-5555

CONSENT TO TREATMENT OF MINOR CHILD

I,_____, am the parent or legal guardian having custody of a minor child, _____. As such parent or legal guardian, I hereby authorize Dr. Dopps and whomever he or she may designates as assistants, to administer chiropractic care as deemed necessary by Dr. Dopps, to my _____(indicate relationship of child).

Dated this _____ day of ____, 20____.

Signed: _____

Witnessed: _____