WESTERVILLE
CHIROPRACTIC & NUTRITION

Patient Contact:

last name: _____ first name:_____ m.i.___
preferred to be called:_____
street:_____
city:_____ state:_____ zip:_____
home phone:_____ cell:_____
work phone:_____ email:_____

Patient Person:

age:_____ date of birth:____/____/_____ social security #:_____-_____-_____
sex: M:__ F:__ status: single___ married___

Emergency Contact:

name:_____ home/cell phone:_____
relationship:_____ work phone:_____

Spouse or Guardian:

last name: _____ first name:_____ m.i.___
employer name:_____
work phone:_____date of birth:____/____/_____

Patient Employment:

employer name:_____ occupation:_____
street:_____
city:_____ state:_____ zip:_____

Which one of our patients referred you to our clinic?_____

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional services may be recommended and I will be advised of applicable costs.

_____ _____

patient or guardian signature date

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