Cornerstone FAMILY CHIROPRACTIC

ADULT HEALTH HISTORY FORM

Discover Health Love Life

Legal Name _____ Preferred Name _____

Gender: □M □ F Date of Birth _____ Cell Phone _____

Home Phone_____ Work Phone_____

Email _____

Whom may we thank for referring you to Cornerstone Family Chiropractic? _____

Home Address _____ City_____ State_____ Zip_____

Marital Status: ☐S ☐M ☐D ☐W Name of Spouse _____

Employment Status: ☐ Employed ☐ Self-Employed ☐ Student ☐ Retired ☐ Not Currently Working

Occupation _____ Employer _____

Emergency Contact: _____Phone_____

Reason for Seeking Chiropractic Care

☐ I do not have any health concerns, complaints, or problems, and I am here for wellness care only

1. What is the **PRIMARY HEALTH CONCERN** that you feel Cornerstone Family Chiropractic can address for you? (There are two more sections to list concerns; start with the one that is giving you the most difficulty)

   _____

   _____

Describe how the problem feels: ☐ Aching ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Shooting ☐ Tightness ☐ Pressure ☐ Tingling ☐ Numbness ☐ Other: _____

Does the pain radiate or travel anywhere? ☐ No ☐ Yes If so, where? _____

When did this begin? ☐ Within past week ☐ Within past month ☐ 1–3 months ☐ 3–6 months ☐ 6–12 months ☐ More than 1 year ☐ Many years Date, if known: _____

How did it begin? ☐ No known cause ☐ Gradually ☐ Suddenly ☐ Motor vehicle accident ☐ Work injury ☐ Sports injury ☐ Fall ☐ Lifting ☐ Repetitive movement ☐ Pregnancy ☐ Postpartum ☐ Other: _____

Is there anything that aggravates the problem? ☐nothing ☐any movement ☐bending neck forward ☐bending neck backward ☐tilting head ☐turning head ☐bending forward at waist ☐bending backward at waist ☐bending to the side at waist ☐twisting at waist ☐driving ☐standing ☐walking ☐running ☐lifting ☐sitting ☐getting up from seated position ☐chewing ☐changing positions ☐lying down ☐reading ☐working ☐exercising ☐laying on side in bed ☐computer use ☐other (please describe):_____

Is there anything that alleviates the problem? ☐nothing ☐resting ☐ice ☐heat ☐stretching ☐exercise ☐walking ☐pain medication ☐muscle relaxers ☐chiropractic ☐massage ☐physical therapy ☐sitting ☐ standing ☐changing positions ☐other_____

On a scale from 0 – 10, with 0 being no pain and 10 being the worst pain you've ever experienced, rate your pain level: Currently____/10 Worst____/10 Best_____/10

What percentage of the time do you experience this problem?

□Occasionally (Less than 25% of the time) □Often (26%-50% of the time) □Frequently (51%-75% of the time) □Constantly (76%-100% of the time)

Since this problem began, is it ☐Improving ☐Staying the same ☐Worsening ☐Comes and goes

Is it worse at a certain time of the day? ☐No difference ☐Morning ☐Afternoon ☐Evening ☐Night

Have you had this condition before? ☐Yes ☐No If yes, When?_____

Have you seen other health care practitioners for this condition? ☐No ☐ Chiropractor ☐ Physical Therapist ☐ Primary Care Provider ☐ Orthopedist ☐Neurologist ☐ Pain Management ☐ Massage Therapist ☐ Acupuncturist ☐ Emergency Room ☐ Urgent Care ☐ Other: _____

If yes, who and where?_____

2. What is the **SECOND HEALTH CONCERN**? (if applicable)

   _____

   _____

Describe how the problem feels: ☐ Aching ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Shooting ☐ Tightness ☐ Pressure ☐ Tingling ☐ Numbness ☐ Other: _____

Does the pain radiate or travel anywhere? ☐ No ☐ Yes If so, where? _____

When did this begin? ☐ Within past week ☐ Within past month ☐ 1–3 months ☐ 3–6 months ☐ 6–12 months ☐ More than 1 year ☐ Many years Date, if known: _____

How did it begin? ☐ No known cause ☐ Gradually ☐ Suddenly ☐ Motor vehicle accident ☐ Work injury ☐ Sports injury ☐ Fall ☐ Lifting ☐ Repetitive movement ☐ Pregnancy ☐ Postpartum ☐ Other: _____

Is there anything that aggravates the problem? ☐nothing ☐any movement ☐bending neck forward ☐bending neck backward ☐tilting head ☐turning head ☐bending forward at waist ☐bending backward at waist ☐bending to the side at waist ☐twisting at waist ☐driving ☐standing ☐walking ☐running ☐lifting ☐sitting ☐getting up from seated position ☐chewing ☐changing positions ☐lying down ☐reading ☐working ☐exercising ☐laying on side in bed ☐computer use ☐other (please describe):_____

Is there anything that alleviates the problem? ☐nothing ☐resting ☐ice ☐heat ☐stretching ☐exercise ☐walking ☐pain medication ☐muscle relaxers ☐chiropractic ☐massage ☐physical therapy ☐sitting ☐ standing ☐changing positions ☐other_____

On a scale from 0 – 10, with 0 being no pain and 10 being the worst pain you've ever experienced, rate your pain level: Currently____/10 Worst____/10 Best_____/10

What percentage of the time do you experience this problem?

□Occasionally (Less than 25% of the time) □Often (26%-50% of the time) □Frequently (51%-75% of the time) □Constantly (76%-100% of the time)

Since this problem began, is it ☐Improving ☐Staying the same ☐Worsening ☐Comes and goes

Is it worse at a certain time of the day? ☐No difference ☐Morning ☐Afternoon ☐Evening ☐Night

Have you had this condition before? ☐Yes ☐No If yes, When?_____

Have you seen other health care practitioners for this condition? ☐No ☐ Chiropractor ☐ Physical Therapist ☐ Primary Care Provider ☐ Orthopedist ☐Neurologist ☐ Pain Management ☐ Massage Therapist ☐ Acupuncturist ☐ Emergency Room ☐ Urgent Care ☐ Other: _____

If yes, who and where?_____

3. What is the **THIRD HEALTH CONCERN**? (if applicable)

   _____

   _____

Describe how the problem feels: ☐ Aching ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Shooting ☐ Tightness ☐ Pressure ☐ Tingling ☐ Numbness ☐ Other: _____

Does the pain radiate or travel anywhere? ☐ No ☐ Yes If so, where? _____

When did this begin? ☐ Within past week ☐ Within past month ☐ 1–3 months ☐ 3–6 months ☐ 6–12 months ☐ More than 1 year ☐ Many years Date, if known: _____

How did it begin? ☐ No known cause ☐ Gradually ☐ Suddenly ☐ Motor vehicle accident ☐ Work injury ☐ Sports injury ☐ Fall ☐ Lifting ☐ Repetitive movement ☐ Pregnancy ☐ Postpartum ☐ Other: _____

Is there anything that aggravates the problem? ☐nothing ☐any movement ☐bending neck forward ☐bending neck backward ☐tilting head ☐turning head ☐bending forward at waist ☐bending backward at waist ☐bending to the side at waist ☐twisting at waist ☐driving ☐standing ☐walking ☐running ☐lifting ☐sitting ☐getting up from seated position ☐chewing ☐changing positions ☐lying down ☐reading ☐working ☐exercising ☐laying on side in bed ☐computer use ☐other (please describe):_____

Is there anything that alleviates the problem? ☐nothing ☐resting ☐ice ☐heat ☐stretching ☐exercise ☐walking ☐pain medication ☐muscle relaxers ☐chiropractic ☐massage ☐physical therapy ☐sitting ☐ standing ☐changing positions ☐other_____

On a scale from 0 – 10, with 0 being no pain and 10 being the worst pain you've ever experienced, rate your pain level: Currently____/10 Worst____/10 Best_____/10

What percentage of the time do you experience this problem?

□Occasionally (Less than 25% of the time) □Often (26%-50% of the time) □Frequently (51%-75% of the time) □Constantly (76%-100% of the time)

Since this problem began, is it ☐Improving ☐Staying the same ☐Worsening ☐Comes and goes

Is it worse at a certain time of the day? ☐No difference ☐Morning ☐Afternoon ☐Evening ☐Night

Have you had this condition before? ☐Yes ☐No If yes, When?_____

Have you seen other health care practitioners for this condition? ☐No ☐ Chiropractor ☐ Physical Therapist ☐ Primary Care Provider ☐ Orthopedist ☐Neurologist ☐ Pain Management ☐ Massage Therapist ☐ Acupuncturist ☐ Emergency Room ☐ Urgent Care ☐ Other: _____

If yes, who and where?_____

HAVE YOU HAD ANY IMAGING FOR ANY OF YOUR HEALTH CONCERNS? □No

	DATE	PROVIDER OR IMAGING CENTER THAT TOOK THE IMAGING
☐X-Ray	_____	_____
☐MRI	_____	_____
☐CT	_____	_____
☐Other: _____	_____	_____

How much are the following activities affected by your health concern(s)?

Activity	None	Mild	Moderate	Severe
Sleeping	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Work/School	☐	☐	☐	☐
Computer Work	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Exercise/Sports	☐	☐	☐	☐
Hobbies/Recreation	☐	☐	☐	☐
Caring for Children/Family	☐	☐	☐	☐
Caring for Pets	☐	☐	☐	☐
Shoveling	☐	☐	☐	☐
Yardwork	☐	☐	☐	☐
Social Life	☐	☐	☐	☐

Activity	None	Mild	Moderate	Severe
Love Life	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Focus	☐	☐	☐	☐
Energy Level	☐	☐	☐	☐
Bowel Function	☐	☐	☐	☐
Bladder Function	☐	☐	☐	☐

Average Hours of Sleep: ☐ Less than 5 ☐ 5–6 ☐ 7–8 ☐ More than 8

What are your goals for receiving chiropractic care? (Check all that apply.)
☐ Reduce pain ☐ Improve mobility/flexibility ☐ Improve daily activities ☐ Improve sleep ☐ Be more comfortable at work/school ☐ Be more comfortable during exercise/sports/recreation ☐ Improve athletic performance ☐ Improve posture ☐ Reduce stress ☐ Increase energy ☐ Prevent future problems ☐ Reduce reliance on pain medication ☐ Avoid surgery ☐ Improve overall health and wellness ☐ Maintain my health with wellness care ☐ Other: _____

Other Data

Have you ever received Chiropractic care? □Yes □No With Whom? _____

Date of last visit_____ **Why did you stop care?** _____

Do you have a family medical doctor? □Yes □No Who? _____

Date of last medical consultation _____

Have you been diagnosed with any of the following conditions:

Musculoskeletal: ☐Arthritis ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Osteoporosis/Osteopenia ☐Fibromyalgia ☐Chronic Pain ☐Scoliosis ☐Herniated Disc ☐Degenerative Disc

Neurological: ☐Headaches ☐Migraines ☐Concussion/Head Injury ☐Stroke/TIA ☐Seizures ☐Neurological Disorder ☐Vertigo/Dizziness ☐Fainting

Cardiovascular: ☐High Blood Pressure ☐Low Blood Pressure ☐Heart Disease ☐Heart Attack ☐Pacemaker ☐High Cholesterol

Respiratory: ☐Asthma ☐COPD ☐Sleep Apnea ☐Sinus Issues

Endocrine: ☐Diabetes Type I ☐Diabetes Type II ☐Thyroid Disease

Digestive: ☐Acid Reflux/GERD ☐IBS ☐Crohn's Disease ☐Ulcerative Colitis ☐Constipation ☐Diarrhea

Other: ☐Kidney Disease ☐Liver Disease ☐Anxiety ☐Depression ☐Allergies ☐Hormonal Imalance ☐Fertility Challenges ☐Cancer — Type: _____ ☐Autoimmune Disease:_____

☐ Other Medical Conditions: _____

☐ None of the above

Women's Health - Complete only if applicable.

Date of last menstrual period: _____

Are you currently pregnant? ☐ No ☐ Yes ☐ It's possible

If yes, weeks pregnant: _____ Due date: _____

Pregnancy complications? ☐ No ☐ Yes — Explain: _____

Previous pregnancies? ☐ No ☐ Yes — number of pregnancies: _____

Any significant complications? _____

Health, Wellness, and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in providing you the best care. Please answer the following questions as accurately and completely as possible.

History of Physical Stresses (Birth to Present)

Birth Stress

Research indicates that the birth process can cause trauma to a baby's spine and nerve system.

Please indicate to the best of your knowledge how you were birthed: (check all that apply)

□ I do not know my birth history

□ drug induced □ C section □ breech □ natural □ forceps

□ prolonged □ cord around neck □ at home □ in hospital □ suction/vacuum

General Physical Trauma

Many traumas occur in the early years (between birth and age 18). It is during those years that your spine and nerve system are growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)
□none □ automobile (even as a passenger) □motorcycle □bicycle □sports □falls □lifting

□other _____ If yes, please explain how and when:

Year Accident or Injury

_____ _____

_____ _____

_____ _____

Have you ever had any surgeries or hospitalizations? □ no If yes, please explain what and when:

Year Surgery or Hospitalization

_____ _____

_____ _____

_____ _____

Have you ever broken any bones? □ no If yes, please explain what and when:

Year	Broken Bone
_____	_____
_____	_____
_____	_____

Work Activity: ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking Frequently ☐ Repetitive Movements ☐ Heavy Lifting ☐ Varies ☐ Not Currently Working

Exercise Frequency: ☐ Never ☐ Sporadically ☐ 1–2 days/week ☐ 3–4 days/week ☐ 5+ days/week

Types of exercise: _____

History of Chemical Stresses

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated? □ yes □ no

Do you or have you ever taken? □ prescription drugs □ over the counter drugs □ recreational drugs

Have you been exposed to? □ chemicals □ fumes □ dust □ smoke

Tobacco/Nicotine: ☐ Never ☐ Former ☐ Current Smoker ☐ Current Vaping ☐ Other Nicotine

Alcohol: ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily

Caffeine: ☐None ☐Less than 1 serving/day ☐1–2 servings/day ☐3–4 servings/day ☐5+ servings/day

How many COVID-19 vaccinations/boosters have you received? _____

Date of most recent vaccination/booster: _____

Did you experience any reaction following a COVID-19 vaccination or booster? ☐ No reaction ☐ Fever ☐ Headache ☐ Blood-clotting concerns ☐ Cardiac concerns ☐ Other: _____

List Current Medications & Supplements Below: ☐ I do not take any medications or supplements.

Medication/Supplement	Dose	Condition/Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of Emotional Stresses

It can be difficult to separate the emotional stress in our life from the physical response that often occurs. **Please indicate if you have experienced any of the emotional stresses below:**

□ Childhood trauma	□ Loss of loved one	□ Relationships	□ Family
□ Work or School	□ Divorce/separation	□ Financial	□ Abuse
□ Lifestyle change	□ Parents' divorce	□ Illness	□ Other_____

Quality of Life

How do you grade your physical health?	□ Good	□ Fair	□ Poor
How do you grade your emotional/mental health?	□ Good	□ Fair	□ Poor
How do you rate your overall "quality of life"?	□ Good	□ Fair	□ Poor

Financial Information

Payment in full is expected for all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

****The cash fee for a new patient is $60.00, which includes the first consult and a chiropractic exam. If it is appropriate and you consent to being adjusted, the first adjustment fee is an additional $45.00. If you're an existing patient and it has been one year since you've been in our office your re-exam fee is $25. If you're an existing patient and it has been three or more years since you've been in the office your re-exam fee is $60.****

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the "Insurance Permission" section below.

Signature _____ Today's Date _____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

"I authorize Cornerstone Family Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."

"I authorize payment be made directly to Cornerstone Family Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature: _____ Date _____

Also, if you are <u>not</u> the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name: _____ Subscriber's date of birth: _____

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice has been emailed to you, is posted in the office, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Cornerstone Family Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

• I give permission to Cornerstone Family Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

•If Cornerstone Family Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

•I give permission to Cornerstone Family Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

•I give Cornerstone Family Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

•I consent to my data being used for research and/or teaching purposes.

•By signing this form you are giving Cornerstone Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Cornerstone Family Chiropractic Family Chiropractic Center plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Cornerstone Family Chiropractic. The written notice must contain the following information: your name, Social Security number, and date of birth; a clear statement of your intent to revoke this authorization; the date of your request; and your signature.

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by Cornerstone Family Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, Cornerstone Family Chiropractic will not refuse to provide treatment however, it will not be possible for Cornerstone Family Chiropractic to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since Cornerstone Family Chiropractic will be unable to contact me 3) all contact with Cornerstone Family Chiropractic regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):

Signature:

Description of Representative's Authority to Act on Patient's Behalf:

_____

Informed Consent

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS

INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.
HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE CORNERSTONE FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____
Patient Signature **Date**

_____
Patient Name

Parental Consent for Minor Patient:

Patient Name: _____ Patient age:_____ DOB: _____

Printed name of person legally authorized to sign for

Parent/Guardian: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____ Date: _____

Signature: _____

Relationship to Patient: _____