Last name **First name**

Address

City, State **Zipcode**

Social Security # **Date of Birth**

Home Phone **Cell Phone** **Email Address (we will NOT give this to anyone)**

Our mission is to provide the highest quality, affordable chiropractic care. With dedication, we promote a better quality of life.

I would like to receive appointment reminders via e-mail ☐yes e-mail:_____☐no

I would like to receive appointment reminders via text messaging ☐yes cell#_____☐no

Cellphone carrier name: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize Goble Heal Chiropractic to release any information to my insurance company/attorney acquired in the course of my examinations or care. I understand that a photocopy of the above assignment and authorizations will be deemed as valid as the original. **I have also been notified of my privacy rights through the HIPAA privacy laws. (see Notice of Information Practices and Privacy Statement)** **TERMS OF ACCEPTANCE** When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal: *to locate, analyze, and correct spinal interference to the nervous system (nerve pressure).* The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (*spinal misalignment producing nerve interference),* in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment, allows the body to function at its optimum level. This allows the inborn healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. We do not diagnose condition(s) or disease(s) other than vertebral subluxations. We offer no treatment of condition(s) or disease(s) other than vertebral subluxations. We promise no cure from any condition(s) or disease(s).

I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

Guardian Signature_____DATE_____

Authorization for Care of Minor:

I hereby authorize this office and it's doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Signed:_____Date:_____

Mother's Name_____ Father's Name_____

Mother's Phone #_____ Father's Phone #_____

Mother's DL #_____Father's DL #_____

Pediatric Patient Introduction

Birth Weight_____Current Weight_____Birth Length_____Current Length_____

Birth History:

Delivery: ☐Normal ☐Vaginal ☐Forceps ☐Breech ☐Cesarean ☐Home ☐Birthing Center ☐Hospital

Infant Feeding: ☐Breast ☐Bottle ☐Formula

APGAR Score_____Was there presence at birth of ☐Jaundice ☐Cyanosis

Congenital Anomalies/Defects:_____

Name of Obstetrician/Midwife/Family MD:_____

Date of last visit to MD:_____Purpose:_____

Immunization history:_____

Has your child ever been treated on an emergency basis?(describe)_____

_____

Present History: Purpose of this appointment:_____

Please note any other special information:_____

_____

_____