Welcome

Todays Date: _____ File # _____

Name: _____

Called Name: _____ ☐ Male ☐ Female

Birthdate: _____ Age: ____ SS#: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ Type: ☐ home ☐ cell ☐ work

Phone #: _____ Type: ☐ home ☐ cell ☐ work

Email Address: _____

Occupation: _____

Employer: _____

Employer Phone Number: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouses Name: _____

Odessa Chiropractic Center
216 South Second Street
Odessa MO, 64076

MINOR CONSENT

I herby authorize Odessa Chiropractic Center and it's Doctor(s) to administer chiropractic care as deemed necessary to my (circle one)

Son / Daughter / Ward

Signed: _____

Print: _____

Date: _____

IN EVENT OF EMERGENCY

Contact: _____

Relation: _____

Phone #: _____

How Did You Hear About Us?

☐ Patient ☐ Dr. Kesemann ☐ Website ☐ Facebook

☐ Phonebook ☐ Other Doctor ☐ Attorney ☐ Other

Referral Name/Website Name:

_____

MEDICAL DOCTOR

Practice: _____

Name: _____

Phone #: _____

City: _____

Person Ultimately Responsible for Account

Name: _____ Relation: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Driver's License #: _____ Phone #: _____

Please make sure to give your driver's license and insurance cards to the front desk to make a copy.

I understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. It is understood and agreed the amount paid to the doctor for x-rays is for examination information only. I agree that I will be responsible for all bills incurred at this office and if my account is not paid within 90 days of the date of service my account will be sent to collections and I am responsible for any legal fees, collection agency fees, or any other expenses incurred in collecting on my account. I understand that any balance due for services is due regardless of results.

Patient Signature: _____ Date: _____

Guardian or Spouses Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer to advise regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is specific adjusting according to correct vertebral subluxations.

I authorize this office to perform any necessary services needed during diagnosis and treatment. I understand that there is no guarantee of clinical results, and that there is no guarantee that any illness, injury, or disease can be prevented or cured by participation in this program. Any balance due for services are due regardless of results.

I, _____, have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Signature: _____ Date:_____