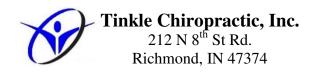


Please fill out this form as completely and accurately as possible. All the information requested below is necessary for us to serve you in the best way possible.

Patient Information:		I	Date:	
Name:		Goes by:		
DOB: Age:	_ SS#	Gender: M	FF	
Married Single Divorced	Separated Widow	ved		
Home Address:				
City:	State:	Zip:		
Home Phone:	_ Cell Phone:			
Work Phone:	_ E-mail:			
Employed Students	dent Retired C	Other		
Employer Name:				
Occupation:				
<b>Emergency Contact:</b>				
Name:				
Home Phone:	_ Cell Phone:			
Work Phone:	_			
Relationship to Patient:				
Who may we Thank for referring you	ı to us?			

We require a copy of your insurance card (if applicable) and your ID.

Please see reverse side for Consent of Treatment



## **Informed Consent for Treatment**

TO THE PATIENT: Please read this entire document prior to si	gning it. It is important you understand
the information contained in this document. Please ask any ques	stions before you sign it if there is
anything that is unclear.	
I,	diagnostic x-rays, ultrasound, muscle Tinkle of Tinkle Chiropractic, Inc. and/or tertain complications which may arise ll feel some stiffness and soreness inkle or his staff of any condition(s) I may ic results are not guaranteed. chiropractic treatments. I have discussed my satisfaction. By signing below, I state ent and have decided that it is in my best
Minor Consent for Chiropract I hereby request and authorize Dr. Jon Tinkle of Tinkle Chiropractic adjustments and other treatment to my minor	actic, Inc. to perform diagnostic tests and
(minor's name). This authorization also extends to office person doctors that may need to examine radiographic images. As of this date, I have the legal right to select and authorize hear named above.	anel and is intended to include other
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTA	AND THE ABOVE.
XSignature of Patient	
Signature of Patient	Date
X	
X	Date