Tinkle Chiropractic, Inc.
212 N 8th St Rd.
Richmond, IN 47374

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: Date: _____

Name: _____ Goes by: _____

DOB: _____ Age: _____ SS# _____ Gender: M ___ F ___

Married ___ Single___ Divorced___ Separated ___ Widowed___

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Employed ___ Unemployed ___ Student ___ Retired ___ Other ___

Employer Name: _____

Occupation: _____

Emergency Contact:

Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Relationship to Patient: _____

Who may we Thank for referring you to us? _____

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

Please see reverse side for Consent of Treatment

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Informed Consent for Treatment

TO THE PATIENT: Please read this entire document prior to signing it. It is important you understand the information contained in this document. Please ask any questions before you sign it if there is anything that is unclear.

I, _____ (Name of Patient) hereby request and consent to chiropractic treatment (also known as chiropractic adjustment or chiropractic manipulative treatments) and any other associated procedures: physical examination, test, diagnostic x-rays, ultrasound, muscle stimulation, physical therapy procedures, etc. on me by Dr. Jon Tinkle of Tinkle Chiropractic, Inc. and/or other assistants.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following treatments. It is my responsibility to inform Dr Jon Tinkle or his staff of any condition(s) I may have prior to and during my treatments. I understand that specific results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic treatments. I have discussed it with Dr. Jon Tinkle and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in the undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment.

Minor Consent for Chiropractic Treatment

I hereby request and authorize Dr. Jon Tinkle of Tinkle Chiropractic, Inc. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor _____ (minor's name). This authorization also extends to office personnel and is intended to include other doctors that may need to examine radiographic images.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Personal Representative (if patient is minor) Date