

Wake Forest Chiropractic
 851 Wake Forest Business Park, Suite E
 Wake Forest, NC 27587
 E-mail: spdc@nc.rr.com

Chart # _____

PATIENT (PLEASE PRINT):
 Name: _____
 Address: _____
 City, State, Zip: _____
 Phone (H): _____ Phone (W): _____
 Mobile/Pager: _____

TYPE OF CASE:
 ___ Auto Accident Date of Injury _____
 Check all that apply: ___ Attorney
 ___ Med-Pay
 ___ Liability
 ___ Health Insurance

___ Worker's Compensation Date of injury _____
 Check all that apply: ___ Attorney
 ___ Employer
 ___ Worker's Comp. Carrier
 ___ Health Insurance

___ Health Insurance
 ___ Primary Only
 ___ Primary & Secondary
 ___ Primary, Secondary & Tertiary

___ Cash/Medicare
 ___ Other

DOB: _____ Gender: M F Age: _____
 Marital Status: _____ SS#: _____
 Spouse's Name: _____ # of children _____
 Closest Living Relative: _____
 Address: _____
 Phone: _____

EMPLOYER/STUDENT
 Name/School: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Occupation: _____

REFERRED BY:
 ___ Primary Care Physician
 ___ Current Patient
 ___ Yellow Pages
 ___ Other _____

CONSENT TO TREATMENT

PATIENT NAME: _____ DATE: _____

- I AUTHORIZE DR. SHAWN PHELAN TO PERFORM THE FOLLOWING PROCEDURE(S) AND TREATMENT: chiropractic adjustment, manipulation, mobilization, heat packing, massage, pressure and trigger point therapy, ice packing, ultrasound, interferential, or alternative treatment that the doctor considers advisable in the opinion, judgment, and conclusion of the aforementioned doctor.
- The nature and purpose of the treatment and possible methods of treatment have been fully explained to me. I understand that chiropractic adjustments, like all treatments, may have side effects. The most common of these is soreness and discomfort. The least common of these (1/1,000,000,000) is neurological damage. We take every precaution in our diagnosis and treatment to screen for and minimize these occurrences.
- I understand that should my regular chiropractor be unable to attend me, my care may be administered by another Doctor of Chiropractic, without another consent being prepared.
- If I am presenting for emergency care coverage, I understand that Dr. Phelan's treatment is specific to the presenting complaint only.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE IN FACT MADE TO ME AND THAT HIS FORM WAS COMPLETED PRIOR TO TREATMENT.

Signature of Patient _____

Please Note: When the patient is a minor or is otherwise incompetent to give consent, the consent of a parent or guardian must be obtained.

Signature of Parent or Guardian _____ Relationship to Patient _____