



SYCUAN MEDICAL DENTAL CENTER

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

Print Patient's Name

Print Name of Patient

Signature of Patient

Print Name of Patient's Representative

Date Signed

Signature of Patient's Representative

To be completed by doctor or staff

Name and address of clinic/office:

Sycuan Medical Dental Center
5442 Sycuan Rd.
El Cajon, CA 92019

Witness to Patient's Signature:

Translated by:

As: _____
Relationship or Authority of Patient's Representative

Date Signed

Print name(s) or doctor(s) treating this patient:

Date: