LUBOVICH CHIROPRACTIC, P. A. 10880 175th Ct. W. Suite 120 • Lakeville, MN 55044 • 952-898-4900

Chart#:_____

NEW PATIENT INFORMATION

Last Name _____ Legal First _____ Middle Initial_____

Sex: ___M___F Birthdate:____/____/____ Height:_____ Weight_____ Single__ Married__ Widowed__ Divorced__

Home Phone#:_____ Cell#:_____

Can we leave a message? ___Y___N Email:_____

Address:_____
street city state zip

Occupation:_____

Employer:_____ Work#:_____

Emergency Contact Name:_____ Relationship:_____

Phone#:_____

Briefly describe symptoms:_____

Have you seen any other doctor for this condition? ___Yes ___No

Check conditions you have or have had in the past:

__Cancer	__High Blood Pressure	__Muscular Dystrophy	__Dizziness	__Rheumatic Fever
__Tuberculosis	__Hepatitis	__Convulsions	__Arthritis	__Nervousness
__German Measles	__Diabetes	__Epilepsy	__Neuritis	__Asthma
__Venereal Disease	__Heart Trouble	__Concussion	__Rheumatism	__Digestive Disorders
__Sinus Trouble	__Backaches	__Numbness	__Anemia	

Have you had any operations? ___Yes ___ No What Kind? _____

Are you allergic to any medications? ___Yes ___ No What Kind? _____

Are you taking any medications? ___Yes ___ No What Kind? _____

Are you pregnant? ___Yes ___No Date of Last Menstrual Period? _____

Are you a smoker? ___Yes ___No How Often? _____

Do you drink alcohol? ___Yes ___No How Often?_____

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Patient Name:_____ Chart#:_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures etc. on me (or patient named below, for whom I am legally responsible) by Dr. Lubovich and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome. Diaphragmatic paralysis, cervical myelopathy and costo- vertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

I hereby acknowledge and assume the potential risks associated with receiving treatment during the COVID-19 pandemic, including becoming infected with COVID-19 through this elective treatment, and give my express permission to you and the staff at your office to proceed with care.

MY PRIVACY

I have had access to a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditations.

FINANCIAL RESPONSIBILITY

I understand and agree that all health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that I am financially responsible for all services not paid for by my insurance. I am also responsible for any deductibles, copayments required by my insurance plan.

I UNDERSTAND THAT FAILURE TO SHOW OR CANCELLING THE SAME DAY AS MY APPOINTMENT WILL RESULT IN A FEE.

MY CERTIFICATION

I certify that the information on this form is correct and I request services.

_____

Patient Signature or person acting on patient's behalf Date

_____

Witness (staff use only) Date