Patient Label
For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

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.

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

____
Print Patient's Name

____
Signature of Patient

____
Date Signed

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

____
Print Name of Patient

____
Print Name of Patient's Representative

____
Signature of Patient's Representative

As:

____
Relationship or Authority of Patient's Representative

____
Date Signed

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

____
Date