

THERAPRACTICS, LLC



PATIENT INFORMATION & DISCLAIMER FORM

Dr. Guy Morrison, R.P.T., D.C.

Full Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Cell _____ Other _____

Date of Birth _____ SSN# _____ Driver's Lic# _____

E-mail address: _____

Gender: Male Female Marital Status: Married Divorced Single Widow/Widower

Spouse/Guardian _____

Date of Birth _____ SSN# _____

Name of person responsible for payment _____

Address _____

City _____ State _____ Zip _____

Are you a student? Yes No Are you Employed? Yes No

Employer _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Are you? Full Time Part Time

Are your symptoms caused by an accident? Y N If yes, date of Accident? _____ Accident type? Car Fall Work Other

I have given the doctor all the information about my health to the best of my knowledge, and have disclosed any recent injuries or illnesses that are essential for the doctor to know in order to treat my condition appropriately and safely.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and/or Physical Therapy. I give authority for these procedures to be performed and will not hold the doctor liable for any injuries that may be sustained in the process of implementing this treatment. The purpose for treatment is to cure and/or relieve symptoms, if present, and to maintain health. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed. The fees agreed upon are to be paid on the same date that services are rendered.

Patient's/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____