

VANDER WEIT CHIROPRACTIC WELLNESS CENTER
314 W. ROLLINS RD., STE. A
ROUND LAKE BEACH, IL 60073
847-546-4220
Dr. Daniel M. Vander Weit

PATIENT INFORMED CONSENT

Patient Name: _____ Date: _____ MR# _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Social Security #: _____

I hereby request and/or consent to the performance of chiropractic adjustments and/or other chiropractic procedures, on me (or on the patient named above for whom I am legally responsible) by Dr. Dan A. Vander Weit and/or his assigned student intern/staff who now and/or in the future may care for me in this office.

I understand and am now informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to strain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or staff and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform an examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

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 procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future conditions(s) for which I seek care.

_____(SEAL) _____
Patient, or Parent/Guardian Signature Date

Doctor's Signature Date

Intern's Signature Date

Staff Signature Date