

SCHIPPEL CHIROPRACTIC

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BACK TO BASICS

www.schippelchiro.com

Date _____

Patient information

Child's Full Name _____

Sex: M / F Date of Birth: _____ Age: _____

Child's Home Phone #: _____

Child's Home Address: _____

City/State/Zip: _____

Email Address of Parent(s): _____

Who is your primary care physician? _____

Are you seeing any other healthcare provider? _____

Who may we thank for referring you to our office? _____

Family information

Mother's Name: _____

Father's Name: _____

Home Phone #: _____

Home Phone #: _____

Work Phone #: _____

Work Phone #: _____

Parent's Marital Status (Circle one): Married Single Divorced Widowed

Consent to treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Hipaa - Notice of privacy policies

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment, or other healthcare operations. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPAA requirements, is available upon request.

Parent's Name: _____ Signature: _____

Date: _____

DISCLAIMER

Please be advised that the nutritional and herbal programs that are administered by our office, and/or Dr. Annette Schippel are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also be advised that any and all testing ordered by our office and/or Dr. Annette Schippel, whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

Please sign to confirm that you have read and understand our disclaimer.

Patient Signature _____ Date _____

Thank you so much for taking the time to fill out this packet of information.

Please meet Dr. Annette Schippel ...



We look so forward to working with and getting to know you. We are dedicated to finding the best individual path for each of our patients.