Contour Chiropractic Clinic PC 10150 NW Glencoe Rd, OR 97133 PH:(503) 336-3335 F:(503)336-3648

Canine Registration Form

Owner's Information

Last Name: _____ First Name: _____ Middle Name: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Physical Address (if different): _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Alternate Phone: _____
Email Address: _____
Referred by: _____

Canine's Information

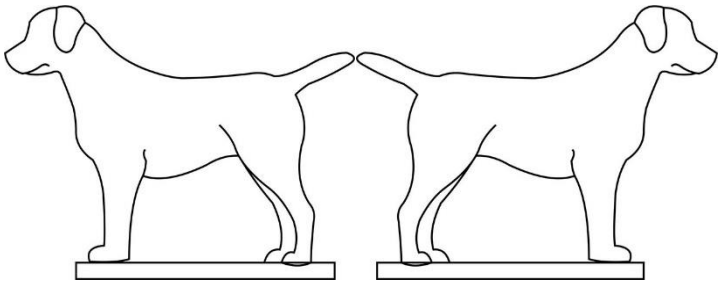
Canine's Name: _____
Breed: _____ Color: _____ Profession: _____
Birthdate: _____ Age: _____ Sex: Male ☐ Female ☐

Veterinarian Information

Veterinarian Clinic: _____ Veterinarian: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

Canine Health Information

Name _____ Date _____
Describe current concern(s): _____
_____
Please mark area of pain on the figures below (if known)



When did this start? _____ Is it getting worse? Yes ☐ No ☐
How do you believe this occurred? _____
_____
Please list any related signs and symptoms: _____
_____
Have you seen anyone else for this current complaint? Yes ☐ No ☐
If yes please list who, where, and when: _____
_____
Has this dog had diagnostic imaging? Yes ☐ No ☐
If yes, please explain when and findings: _____
_____
Have you tried any other therapies? Yes ☐ No ☐
If yes, please explain: _____
_____
Please list any current medication, minerals, herbs, or vitamins: _____
Please list any allergies (medication, food, herbs, etc.): _____

Consent to Treat

Owner's Name: _____, Canine's Name: _____,
I hereby request and authorize Dr. Ann Lauzon to perform diagnostic tests and render chiropractic adjustments and other treatments including but not limited to; heat/cold packs, traction, cold laser, electrical muscle stimulation, manual muscle therapies, ultrasound, etc. I understand that these procedures are considered to be safe and effective methods of care, however, complications may arise. While these complications are considered rare, it is the practice of Contour Chiropractic Clinic PC to make all patients aware of them. Some of these complications include but are not limited to soreness, dizziness, temporary worsening of symptoms, inflammation, burns, and etc. I extend this authorization to include other doctors or staff members that may be affiliated with this clinic. I understand that this authorization is intended to include radiographic/magnetic imaging at the doctor's discretion.

I have read and completely understand the above statements regarding chiropractic care. I also understand that there is no guarantee that chiropractic care will provide a specific cure or result.

I also verify that I am the legal owner, or have legal right as of today's date, to authorize health care services for the canine stated above. If my authority to authorize such treatment or care should change or is modified in any way, I will notify the Clinic.

Signature _____ Date _____

Awareness of Privacy Practices

I, (please print full name) _____, am aware and understand Contour Chiropractic Clinic PC will not release information regarding my canine without consent. In addition, I authorize medical providers and personal of Contour Chiropractic Clinic PC to have electronic correspondence including by phone, fax, and email provided on intake.

Signature _____ Date _____

Financial Policy

Payment at the time of service
Payments may be made by cash, check, or credit/debit card. By paying at the time of service, you will receive a discount which is only valid when payment is received on the same day the service is provided. If you are unable to pay in full at the time of service you will be billed at the standard office rates, it is your responsibility to contact our office to arrange a payment plan.

Missed appointments
24-hour notice is required for cancellation of appointments with this office, cancellation by voicemail made at least 24 hours before appointment is accepted. This office reserves the right to charge standard rates for any appointments that are not cancelled with advanced notice.

Patient's Agreement
I have completely read and understand the Financial Policy of Contour Chiropractic Clinic PC. I understand and agree that I am responsible for payment for services and products provided by this clinic. I am also responsible for payment of any fees that may accumulate while trying to collect my unpaid balance; including but not limited to attorney fees.

Signature _____ Date _____