CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Sex: ☐ M ☐ F Home phone # _____

Cell phone # _____ E-mail address _____

Address _____ City/State _____ Zip _____

Age _____ Birth date _____ Marital status: M S W D # of children _____ Ages _____

Social Security # _____ Occupation _____

Employer _____ Phone # _____

Emp. address _____ City/State _____ Zip _____

Referred by _____ Name of parents (if minor) _____

Spouse's: name _____ Social Security # _____

Occupation _____ Employer _____ Phone # _____

Patient's nearest relative _____ Phone # (_____) _____

Date of last physical examination _____ Location/Facility _____

List all surgeries & dates _____

List any serious illnesses & dates _____

Do you suspect that you might be pregnant? (women only) ☐ YES ☐ NO Date of LMP _____

Reason for care/appointment and/or
Nature of problem/complaint _____

When did Symptom/Complaint first appear? _____ Explain _____

Please record your symptoms:
(**C = current / P = past**)

1. ____ Dizziness
2. ____ Headache
3. ____ Neck pain
4. ____ Backache
5. ____ Shoulder pain
6. ____ Arm Pain
7. ____ Arm Numbness
8. ____ Sciatica/Leg Pain
9. ____ Leg Numbness
10. ____ Asthma
11. ____ Allergy
12. ____ Sinus Trouble
13. ____ Ear Problems
14. ____ Heart Problems
15. ____ Tuberculosis
16. ____ Digestive Disorders
17. ____ Arthritis
18. ____ Rheumatic Fever
19. ____ Anemia
20. ____ High Blood Pressure
21. ____ Diabetes
22. ____ Nervous Conditions
23. ____ AIDS or HIV Positive
24. ____ Stroke/TIA
25. ____ Cancer (explain) _____

List family history of the above conditions? _____

Other Dr.s seen for this condition _____ ☐DC☐MD☐OB/GYN☐DO Other _____

Have you been treated for any other health condition(s) recently? ☐YES ☐NO Describe _____

List medications/drugs are you taking _____

Name of person responsible for payment _____

Are you covered by health insurance? ☐YES ☐NO Name of company _____

Please read and sign below:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare claim forms to assist me in making collection from the insurance company and that any amount(s) authorized to be paid directly to the Miller Chiropractic Office will be credited to my account upon receipt. However, I also clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all bills incurred in this office. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as deemed appropriate through the use of manipulation/adjustments. It is understood and agreed that the amount paid to the Doctor for X-rays is for examination only and that the X-ray films will remain the property of this office, being on file for 7 years where they may be seen at an agreed time while an active patient of this office. I understand that chiropractic cannot guarantee results and, as with any procedure, there may be some inherent risks. It is also understood that the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I warrant that the information provided by me is true and correct.

Patient's Signature _____ **Date** _____

Guardian or Spouse's Signature Authorizing Care _____ **Date** _____

FOR* INJURIES / ACCIDENTS *PLEASE ALSO COMPLETE THE OTHER SIDE