Miller Clark Chiropractic
New Patient Registration

Name: ______________________ Called Name: ______________________

Address: ______________________ City: ______________ State: _____ Zip Code: ________

Birthdate: _____/_____/_____ Age: _____ SS#: ______________________ Male_____ Female_____

Home #: ______________ Cell #: ______________ Work #: ______________

Status: Single____ Divorced____ Separated____ Widowed____ Married____ Spouse's name: ______________

Do you have children: Y N If so, how many: _____ Referred by: ______________________

Employer: ______________ Occupation: ______________ How long: ______

Please tell us what type of care you are interested in: Chiropractic Care _____ Spinal Decompression _____
Massage Therapy_____ Acupuncture _____

INSURANCE INFORMATION

PRIMARY Insurance: ______________________
Insured's Name: ______________________
Insured's Relation: ______________________
Insured's Employer: ______________________
Insured's DOB: _______/_______/_______

SECONDARY Insurance: ______________________
Insured's Name: ______________________
Insured's Relation: ______________________
Insured's Employer: ______________________
Insured's DOB: _______/_______/_______

ACCOUNT INFORMATION

Personal ultimately responsible for this account

Self_______ If not self, please continue
(initials)
Name: ______________________
Relation: ______________________
Billing address: ______________________
____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (If offered at this office) _______ **(initials)**

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. ________ **(initials)** Date: ______/______/______
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. ________ **(initials)** Date: ______/______/______
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. ________ **(initials)**

Patient Signature: ______________________ **Date:** ______/______/______

In Event of Emergency

Whom should we contact: ________________________ Relation: ____________________

Phone #: (______)____________________ (Circle one) Cell Home Work

Who is your Medical Doctor: ________________________ Doctor's phone #: ____________________

Reason for today's visit

Reason for visit: Emergency_____ New injury_____ Old injury_____ Chronic pain_____ Wellness_____

Did your injury occur during: Work_____ Sports_____ Auto Accident_____ Daily/Routine Activity_____ Unknown_____

When did your condition/accident occur: ______/______/______ Where did it happen: ______________________________

Please explain what happened: ______________________________

Are you in pain now: Yes_____ No_____ Rate your pain level on the following scale ______________________

mild 1 2 3 4 5 6 7 8 9 10 severe

Is your condition getting worse: Yes_____ No_____ Is your pain: Constant _____ Intermittent _____

Has any other Medical Physician treated you for this condition: Yes_____ No_____
If so, where: ______________________

Have you ever been treated by a Chiropractor: Yes_____ No_____
If so, where: ______________________ How long ago: ______

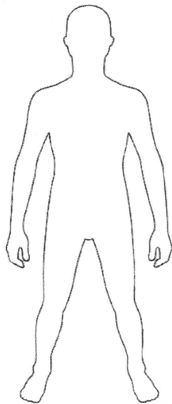
Please list any surgeries and dates: ______________________________
____

Are you allergic to anything: ______________________________

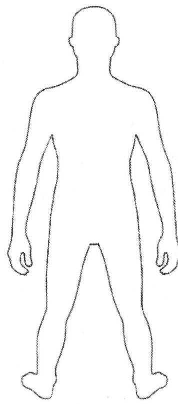
Do you exercise: Yes____ No____ How many hours per week: _______

For women: Are you taking Birth Control: Yes_____ No_____ Are you nursing: Yes _____ No_____
Are you pregnant: Yes_____ No_____ If so, how many weeks: ________

Please circle the body part for today's visit



Front



Back

Do you or have you had any of the following:

Condition	Y	N
Heart Attack/Stroke	Y	N
Artificial Valve	Y	N
Shingles	Y	N
Heart Surgery/Pacemaker	Y	N
Alcohol/Drug Abuse	Y	N
Cancer	Y	N
Heart Murmur	Y	N
High/Low Blood Pressure	Y	N
Psychiatric Problems	Y	N
Frequent Neck Pain	Y	N
Sinus Problems	Y	N
Lower Back	Y	N
Congenital Heart Defect	Y	N
Ulcers/Colitis	Y	N
Fainting/Seizures/Epilepsy	Y	N
Arthritis	Y	N
Frequent Headaches	Y	N
Emphysema/Asthma	Y	N
Artificial Bones/Joints/Implants	Y	N
Hepatitis	Y	N
HIV/AIDS/ARC	Y	N
Anemia/Diabetes	Y	N
Kidney Problems	Y	N
Chemotherapy	Y	N
Venereal Disease	Y	N