Miller Chiropractic

PATIENT HEALTH HISTORY FORM

PATIENT INFORMATION			
❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss	Last Name:	First:	Middle:
Marital status (circle one): Sin / Mar / Div / Wid	Birth date: / /	Age:	Gender: ❑ M ❑ F
Street address:		P.O. Box:	
City:	State:	Zip Code:	
Cell phone #:	Home phone #:	# of Children:	
Email:	SS#:		
Occupation:	Employer Name:	Employer phone #:	
Employer address:			
City:	State:	Zip Code:	
Emergency Contact:	Phone:		
Who may we thank for referring you to our practice?			

CURRENT COMPLAINT
Nature of Injury: ❑ Automobile ❑ Work ❑ Other Date of accident:
Describe the major complaints that brought you to our office:
Have you ever had same condition?
List of other practitioners seen for this injury/condition:
Have you ever been under chiropractic care? ❑ Yes ❑ No If yes, please describe:
Height: _____ Weight: _____
Payment Options: (Please Indicate): ❑ At time of Service ❑ Bill Insurance (fill in information below)

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Subscriber's name:		Subscriber's Birthdate: / /	
Address (if different):	City:	State:	Zip:
Insurance Company:			
Insurance ID.:		Group No.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary insurance (if applicable):		Subscriber's name:	
Insurance ID.:		Group No.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		Subscriber's Birthdate: / /	

Dr's Signature: _____ *Date:*_____

Medical History	
Have you been treated for any conditions in the last year? ❑ No ❑ Yes If yes, please describe:	
Date of last Physical Exam:	
Is there a chance that you are pregnant? ❑ No ❑ Yes	
Have you had X-rays taken? ❑ No ❑ Yes If yes, Where?	
Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
What activities aggravate your symptoms?	

Have you ever:	**No**	**Yes**	**Briefly Explain**
Broken bones?	❑	❑	
Been hospitalized?	❑	❑	
Been in an auto accident?	❑	❑	
Had Sprains/Strains?	❑	❑	
Been struck unconscious?	❑	❑	
Had surgery?	❑	❑	

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco - everyday ❑ occasional ❑ former ❑ never ❑				
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

Family Medical History (*Records one diagnosis in your family history and the affected relative)*				
Diagnosis (Write in below)	**Father**	**Mother**	**Sibling: (_____)**	**Offspring: (_____)**
Example: Heart Disease				

Are you currently taking any medications? Yes ❑ No ❑ *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)
Do you have any medication allergies? Yes ❑ No ❑ If **yes,** please list:	

Name:_____ Date: _____

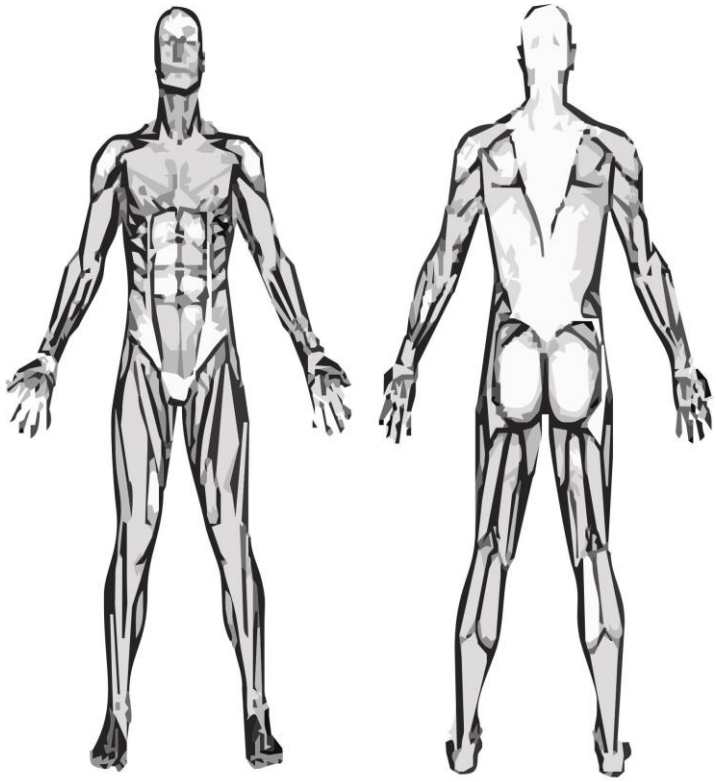
Dr's Signature: _____ *Date:*_____

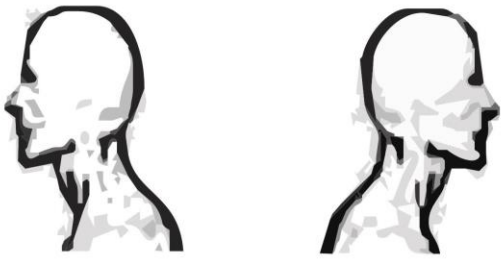
Have you ever suffered from:

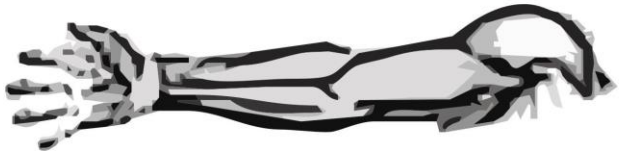
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain/Conditions
- ❑ Cold Extremities
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Ears Ring
- ❑ Excessive Menstruation
- ❑ Eye Pain or Difficulties
- ❑ Fatigue
- ❑ Frequent urination
- ❑ Headache
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Irregular Heart Beat
- ❑ Irregular Cycle
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Loss of memory
- ❑ Loss of balance
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Lumps in Breast
- ❑ Neck Pain or Stiffness
- ❑ Nervousness
- ❑ Nosebleeds
- ❑ Pacemaker
- ❑ Polio
- ❑ Poor Posture
- ❑ Prostate Trouble
- ❑ Sciatica
- ❑ Shortness of breath
- ❑ Sinus Infection
- ❑ Sleep problems or Insomnia
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Swollen Joints
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Other

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A = Ache
B = Burning
N =Numbness
O = Other
P = Pins & Needles
S = Stabbing







Name:_____ Date: _____

Dr's Signature: _____*Date:*_____

MILLER CHIROPRACTIC MULTIPLE AUTHORIZATION FORM

FINANCIAL AGREEMENT

Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you. In the event that my insurance will pay all or part of Miller Chiropractic's charges, Miller Chiropractic which renders services to me is authorized to submit a claim for payment to my insurance carrier. Miller Chiropractic is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. **I understand that unpaid fees for services beyond thirty (30) days are subject to 18% finance charge as well as a $25 monthly late fee.**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Miller Chiropractic. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of Miller Chiropractic who renders service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage and my patient demographics is correct.

CONSENT TO USE PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Miller Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

ACCOUNT AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize Miller Chiropractic and/or Dr. Terrence Miller to communicate information regarding my account and/or billing to:

My spouse/family member/other(s): _____ _____initials

May we leave you a message on an answering machine/voice mail: Yes ☐ No ☐ _____initials

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____

Signature of Patient (or Responsible Party if minor) **Print** – Patient Name

_____ _____

Relationship to Patient **Date**

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and 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 above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

Name and address of office:

Miller Chiropractic
242 Center Street
Grayslake IL 60030
847-223-4511

Print name of doctor treating this patient:

Terrence R. Miller DC