Miller Chiropractic Center PLLC

Vaughn S, Miller, D.C.
618 Westport Rd.
Elizabethtown, KY 42701

Confidential Patient History

Today's Date _____

Name _____ Street Address _____
(First) (Last) (Mid. Int.)

City _____ State _____ Zip _____ Home Phone # _____

Date of Birth _____ Age _____ Sex _____Cell Phone # _____

SS# _____ Marital Status: M S W D E-Mail Address_____

Employer's Name _____ Job Title _____ Wk Phone # _____

Spouse's Name _____ Employer _____ Wk Phone # _____

In case of an Emergency, Please list Name of Relative or a Close Friend that's *Not* living in your Home:

Name _____ Phone # _____ Relationship _____

Referred By _____ Cell Phone # _____

Females: Are You Pregnant? [ ] Yes [ ] No [ ] Not sure

Do you *Currently* have:

1. Headaches? [ ] Yes [ ] No
2. A.I.D.S.? [ ] Yes [ ] No
3. Hepatitis A? [ ] Yes [ ] No
4. Blockage of the Blood Vessels or Arteries in your neck? [ ] Yes [ ] No
5. Hepatitis B (Serum)? [ ] Yes [ ] No
6. High Blood Pressure? [ ] Yes [ ] No
7. Low Blood Pressure? [ ] Yes [ ] No

Have you had Chiropractic Care before? [ ] Yes [ ] No If "Yes", when or how long ago? _____

Name of Chiropractor _____ City _____ State _____

Name of Medical Doctor _____ City _____ State _____

Please List *ALL* your *Present* Major Complaints and Symptoms: (Describe in detail)

1. _____ How far back in history does this complaint go? _____

When did it get as bad as it is now?_____ Is the pain there all the time or does it come and go? _____

If it comes and goes, you notice it when you do what? Or it shows up how often? _____

On a scale from 1 – 10, 10 being severe, how would you rate your symptoms? If it varies, give us two numbers like 4 to 9. _____

2. _____ How far back in history does this complaint go? _____

When did it get as bad as it is now?_____ Is the pain there all the time or does it come and go? _____

If it comes and goes, you notice it when you do what? Or it shows up how often? _____

On a scale from 1 – 10, 10 being severe, how would you rate your symptoms? If it varies, give us two numbers like 4 to 9.
_____

3. _____ How far back in history does this complaint go?
_____

When did it get as bad as it is now?_____ Is the pain there all the time or does it come and go?
_____

If it comes and goes, you notice it when you do what? Or it shows up how often?
_____

On a scale from 1 – 10, 10 being severe, how would you rate your symptoms? If it varies, give us two numbers like 4 to 9.
_____

4. _____ How far back in history does this complaint go?
_____

When did it get as bad as it is now?_____ Is the pain there all the time or does it come and go?
_____

If it comes and goes, you notice it when you do what? Or it shows up how often?
_____

On a scale from 1 – 10, 10 being severe, how would you rate your symptoms? If it varies, give us two numbers like 4 to 9.
_____

Have you consulted with another Doctor for your **Injury/<u>Present Complaint(s)</u>?** [ ] Yes [ ] No

If "Yes", which type of Doctor? [ ] Medical [ ] Orthopedic [ ] Chiropractic [ ] Neurologist [ ] Osteopath [ ] Other

Physician's Name _____ City _____ Referred by
_____

What was the Dr.'s diagnosis? _____

Did they take X-rays? [ ] Yes [ ] No What part of your body? _____ When?
_____

How long did you see this Physician? _____ What were the results?
_____

What type of treatment did you receive?
_____

Is this condition a result of an automobile accident? [ ] Yes [ ] No

If "Yes:, do you want us to submit your account to the liable Automobile Insurance? [ ] Yes [ ] No

Is this condition a result of an On-The-Job-Injury? [ ] Yes [ ] No

If "Yes", do you want us to submit your account to Worker's Compensation Insurance? [ ] Yes [ ] No

Insurance Co. Name _____ Address
_____

Insurance Co. Phone # _____ Date of Accident
_____

What medications are you currently taking **<u>and</u>** what are they for?
_____

_____.

Do you have Health Insurance? [ ] Yes [ ] No Name of Insurance Company _____

Insured's Name _____Insured's Employer _____

Insured's Date of Birth. _____ Insured's SS# _____ Do you have a deductible? [ ] Yes [ ] No

How much is your deductible? _____ How much of your deductible has been met? _____

Name of person responsible for your account: _____ Relationship _____

I UNDERSTAND AND AGREE THAT HELATH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT *MILLER CHIROPRCTIC CENTER PLLC* WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO *MILLER CHIROPRACTIC CENTER PLLC* WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

You have the right to rescind within 72 hours, any obligation to pay for services performed in addition to any discounted services.