Miller Chiropractic of Fair Oaks

New Patient Form

PATIENT INFORMATION

Name: _____ Preferred: _____

Date of Birth: _____ Gender: Male Female Pregnant: Yes No

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Emergency Contact: _____ Phone #: _____

Have you ever received chiropractic care before? If so, when? _____

_____

REASON FOR VISIT

My condition is related to: (circle all that apply)

Work Sports Auto Personal Injury Chronic Acute Not Sure

Briefly describe the condition and its location: _____

_____

_____

Is your condition/pain any of the below (circle all that apply)

Burning Sharp Dull Constant Intermittent

When did the condition begin: _____

List any doctors you have seen and treatment you received for this condition: _____

_____

_____

_____

RELEASE OF INFORMATION

I hearby authorize Miller Chiropractic of Fair Oaks, PC to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this caase, and hereby release Miller Chiropractic of Fair Oaks, PC of any consequence thereof.

Patient Name: _____Date:_____

Patient Signature: _____Date:_____

INSURANCE AUTHORIZATION

I hereby authorize payment of insurance benefits, otherwise payable to me, direct to Miller Chiropractic of Fair Oaks, PC

Patient Name:_____Date:_____

Patient Signature:_____Date:_____

CANCELLATION AND NO SHOW POLICY

We require a 24-hour notice so that we have the opportunity to offer your appointment time to another patient. However we understand emergencies happen so we will work with you to reschedule your appointment. Text messages (or phone calls, if you prefer) will be sent out in advance the day of your appointment. No shows will be charged a $25 fee.

I understand the terms of the cancellation/no show policy. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company.

Patient Signature: _____Date:_____