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 #: _____________________________

Employer: ____ Occupation: _________________________

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: ____

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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: ________________________

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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:___________________