Miller Chiropractic Of Fair Oaks

WELCOME TO MILLER CHIROPRACTIC OF FAIR OAKS, P.C.

Patient Contact Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home): _____ (Work): _____

(Cell): _____

E-Mail: _____

Patient Demographics

Date of Birth: _____ Gender (circle one): Male Female

Social Security #: _____ Marital Status (circle one): Single Married Other

If MARRIED, Spouse's Name: _____

If MARRIED, Spouse's Contact Phone: _____

Employment Status (circle one): Employed Full-Time Student Part-Time Student Other

If EMPLOYED, Employer's Address: _____

Referral Information

Name of Primary Care Physician (PCP): _____

PCP's Phone Number: _____

Referring Doctor (if different from PCP): _____

Referring Doctor's Phone Number: _____

Miller Chiropractic of Fair Oaks, P.C.
12011 Lee Jackson Highway, Suite 100, Fairfax, VA 22033
Phone: 703-352-0706 Fax: 703-352-6954 E-Mail: info@millerchiropracticoffairoaks.com
http://www.millerchiropracticoffairoaks.com

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Emergency Contact

Emergency Contact's Name: _____

Relationship To You: _____

Emergency Contact's Phone Number: _____

Reason For Visit

My condition is related to (circle all that apply): Work Sports Auto Personal Injury Chronic

What Happened: _____

_____

Describe The Condition & It's Location: _____

_____

Is your condition/pain (circle any that apply): Burning Sharp Dull Constant Intermittent

When did the condition begin? _____

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

_____

_____

Have you previously been under chiropractic care: _____

Health History

List any previous surgeries you have had: _____

_____

List any past and current major medical conditions or diseases that you have had: _____

_____

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Health History Continued

List any ongoing and current medications you take: _____

_____

FOR WOMEN ONLY

(Please circle your answer)

Are you currently pregnant: YES NO

Are you currently using an oral contraceptive: YES NO

Insurance Information

IF INSURED by MEDICARE, date of last X-RAY: _____

Relationship to Insured: _____

If NOT SELF, Name of Insured: _____

Insured's Address: _____

Insured's Phone Number: _____ Insured's DOB: _____

Insured's Social Security #: _____ Insured's Gender (circle one): Male Female

Insured's Employer: _____

Insured's Employer's Address: _____

By signing, I agree that this case history contains information which is true and accurate to the best of my knowledge.

By signing, I agree that I am responsible for payment at the time that services are rendered, unless other payment arrangements have been made. If I utilize insurance for my care, I agree to pay the amount which my insurance company determines to be my responsibility. If I do not use insurance for my care, I understand that I am responsible for payment in full for the services which are rendered to me.

Signature: _____ **Date:** _____

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Release of Information

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

Patient Name: _____ **Date:** _____

Patient or Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Insurance Authorization

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

Patient Name: _____ **Date:** _____

Patient or Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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