New Patient Form

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DrDylanMiller.com

Miller Chiropractic

Date

PERSONAL INFORMATION

Name

Address

City/State/Zip

Home Phone | Work Phone | Cell Phone

Email

Date of Birth

Marital Status | Sex (M/F) | Age

Occupation | Referred By

Emergency Contact Name/Phone

Spouce / Parent / Guardian

CURRENT HEALTH CONDITION

Purpose of this appointment

Today's condition started when?

Please list all medical diagnosis/conditions you are currently being treated for

Other doctors seen for this condition

Type of treatment

Results

Please list medications

Please list vitamins, herbs, and supplements

YOUR LIFESTYLE

- Alcohol
- Tobacco
- Marijuana
- Drugs
- Stress
- Occupational hazards
- Regular exercise
- Type _____ Frequency _____
- Type _____ Frequency _____

FEMALES, PLEASE COMPLETE

- Pregnant
- Planning pregnancy
- Menstrual flow regular/irregular/pain
- Days of flow
- Length of cycle
- First day of your last period
- Pain/Bleeding during or after sex

Number of:

Pregnancies _____
Abortions _____
Miscarriages _____
Live births _____
Bird control method _____
Birth control pill name _____

- Flushing/Menopause

Date of last PAP test _____

- Normal
- Abnormal

Date of last mammogram

- Normal
- Abnormal

HOSPITALIZATIONS, SERIOUS ILLNESS, SURGERIES

Date _____
Reason _____

Date _____
Reason _____

Date _____
Reason _____

Date _____
Reason _____

MEDICAL HISTORY

- Ringing in ear
- Frequent ear infections
- Dizziness/Fainting
- Failing vision
- Eye infections
- Nose bleeds
- Sinus trouble
- Frequent sore throats
- Hayfever/ Allergies
- Pneumonia
- Bronchitis/Chronic cough
- Asthma/Wheezing
- Chest pain
- High blood pressure
- Heart trouble
- Swollen ankles
- Leg pain (walking)
- Varicose veins/phlebitis
- Loss of appetite
- Difficulty swallowing
- Indigestion/Heartburn
- Persistent nausea/vomiting
- Ulcers
- Chronic abdominal pain
- Gall bladder trouble
- Jaundice/Hepatitis
- Change in bowel habits
- Diarrhea
- Constipation
- Diverticulosis
- Crohn's/Colitis
- Bloody/Tarry stools
- Hemorrhoids
- Hernia
- Headaches
- Parasites
- Yeast/Candida
- Urinary Trouble
- HIV/AIDS
- Decrease in force/flow of urinatio
- Recent weight loss
- Anemia
- Bruise easily
- Cancer
- Kidney stones
- Venereal disease
- Chronic fatigue
- Diabetes
- Thyroid disease
- Convulsions/Seizures
- Stroke
- Tremor/Hands shaking
- Muscle weakness
- Numbness/Tingling sensations
- Frequent headaches
- Arthritis/Rheumatism
- Osteoporosis
- Recurrent back pain
- Bone fracture/join injury
- Gout
- Foot Pain
- Numbness
- Rashes/Hives
- Psoriasis
- Eczema
- Nervousness
- Depression
- Memory loss
- Excessive moodiness
- Mental illness
- Phobias
- Lactose intolerance
- Prostate problems
- Frequent infections
- Trauma/Abuse
- Physical Abuse
- Emotional Abuse
- Verbal Abuse
- Sexual Abuse
- Financial Stress
- Other _____

FAMILY HISTORY (Have any blood relatives had the following illnesses? If so, please indicate the relationship.)

Illness	Family Members
Diabetes	
Cancer	
Blood disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Tuberculosis	
Gout	
High blood pressure	
Heart disease	
Other	

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand that all services are rendered on a cash, check, or credit/debit card basis. I agree to pay for each appointment at the time of the appointment. I understand that I am responsible for any debts incurred at this office. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation.

Name of Person Responsible for Payment:

Address & Phone (if different than yours):

Date:

Signature or Initials:

CONSENT TO EXAMINATION AND TREATMENT

Dr. Dylan Miller utilizes Professional Applied Kinesiology (PAK) & Diagnostic Muscle Testing as part of his evaluation process. PAK does not diagnose pathological medical conditions or disease processes. However, PAK evaluates for and identifies functional health conditions.

Dr. Miller combines the information he obtains from any necessary medical testing with Diagnostic Muscle Testing, a thorough medical history, and a systems survey to arrive at a clinical diagnosis and develop a treatment plan.

I hereby give permission to Dr. Dylan Miller to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and treatment of my condition. I have read and agree with the above statements.

Patient Name:

Date:

CONSENT FOR USE OF PATIENT HEALTH INFORMATION (PHI)

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree to how your records will be used.

- The patient understands and agrees to allow Miller Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
- The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.
- A patient's written consent need only be obtained one time for the subsequent care given in this office.
- The patient may provide a written request to revoke consent at any time during care. This will not affect the use of those records for care given prior to the written request to revoke consent, but it will apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all known precautions to ensure that your records are not readily available to those who do not need them.

If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse care.

Patient Name:

Date: