Miller Chiropractic Health Center

New Patient Preliminary Questionnaire

Patient Name:_____ Soc. Sec. No:_____
(First) (Middle) (Last)

Home Address:_____ Date of Birth:_____
(Street) (City, State, Zip Code)

Occupation:_____ Work Phone:_____ Home Phone:_____

Female Patients: Are You Pregnant?_____ Cell Phone:_____

What are your main problems?_____

_____

_____

Date of injury/Beginning of illness:_____ Time:_____ AM or PM

Location of Accident:_____

How did it happen? _____Auto Accident _____At Work _____Other_____

Please describe how it happened:_____

_____

Have you lost time from work?_____ Dates:_____

Have you received any other health care for this problem?_____ Describe:_____

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Who is Responsible for this account?

IS THIS CASE COVERED BY INSURANCE? PLEASE INDICATE WHAT TYPE OF INSURANCE YOU HAVE:

BLUE CROSS/BLUE SHIELD_____ MEDICARE_____ GROUP INSURANCE_____

AUTO INSURANCE_____ PERSONAL INJURY_____ OTHER INSURANCE_____

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST TO BE PHOTOCOPIED

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment.

Signature_____ Date_____