Personal Injury/ Auto Accident

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Patient registration

Please answer all applicable question, leave blank if not applicable

Name_____

DOB _____(MM/DD/YYYY) **Gender**(Circle Answer): Male Female Other

Email_____

Address _____

City_____**State**_____**Zip** _____

Cell Phone_____**Home Phone** _____

Emergency Contact Name:_____

Relation: _____ Phone # _____

Patient employer: _____

Have you lost any time from work?(Circle Answer) Yes No

Do you need a note for work?(Circle Answer) Yes No

Do you have a **Pacemaker** or **defibrillator?**(Circle Answer) Yes No

Height :_____ Weight : _____

For **Females:** (Circle Answer)

Are you pregnant? Yes No Do you take birth control pills? Yes No

Date of accident/Incident:_____-_____-_____ **MM-DD-YYYY**

Did you go to **Hospital/ER** for your accident?(Circle Answer) Yes NO (leave blank if not applicable)

Please list **NAME of Hospital or ER**_____

If you went at a later date than accident please list here (MM-DD-YYYY) _____- _____- _____

How did you get to the hospital:_____

Medication prescribed:_____

_____

Did you receive any of these tests ? (Circle any tests apply)

MRI CT Scan X-ray Ultrasound

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Accident/Incident Type(Circle Answer):

18 wheeler Rear-ended Accident Head-on collision Sideswiped accident

T-Bone Accident Slip & Fall

Was there a **police report** filed:(Circle Answer) Yes NO

Were you wearing a **seat belt**? (Circle Answer) None Lap belt with shoulder harness

Shoulder Harness Lap belt

Was **airbag** deployed:(Circle Answer) Yes NO

Your role was:(Circle Answer)

Driver of Vehicle Driver of motorcycle Back seat passenger Front seat passenger

Please describe the Accident/Incident: _____

_____

_____

_____

_____

Place of Incident(if slip & fall): _____

Did you Report the Incident?(if slip & fall)(Circle Answer) YES NO

(If yes to whom)?_____

Write your description of what you are feeling: _____

_____

_____

_____

Are you experiencing any of the following since your injury? (Circle all that apply)

Anxiety	Ankle/Foot Pain	Blurry vision	Breathing Problems
Chest Pain	Dizziness/Loss of balance	Elbow Pain	Fatigue
Hip Pain	Headaches	Knee Pain	Low Back Pain
Memory lapses	Mid Back Pain	Neck Pain	Numbness/Tingling to Arm/Hand
Numbness/Tingling to Leg/Foot	Shoulder Pain	Upper Back Pain	Wrist/Hand Pain

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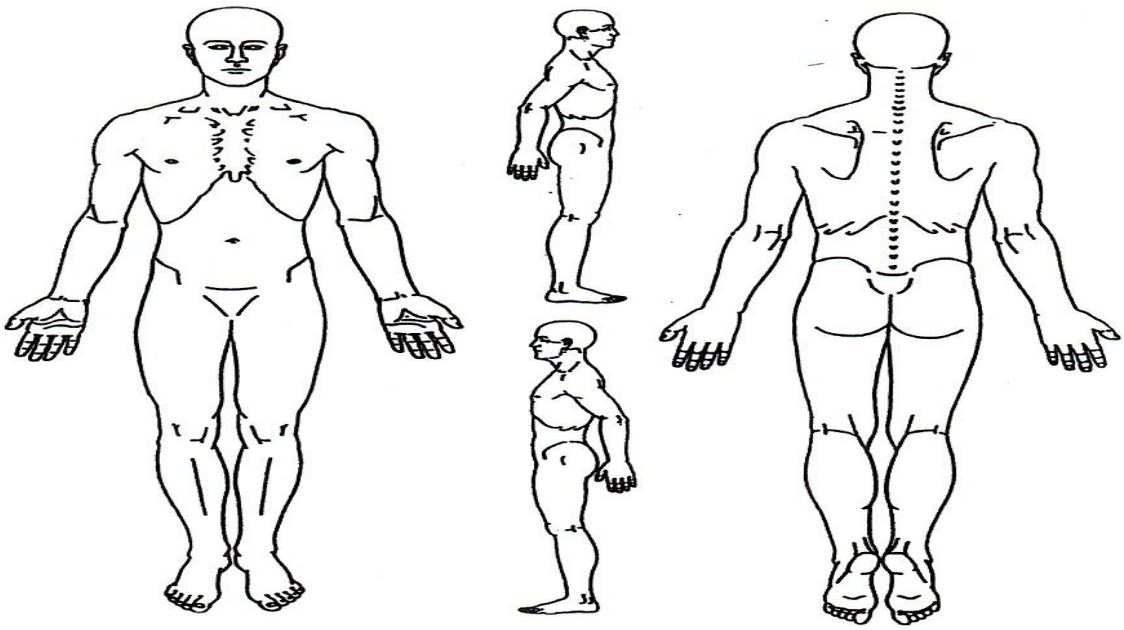
Circle all that apply:

Indicate on the diagrams below the location/s on body and circle type of sensation/s you have been experiencing. Circle all that apply:

Ache	Burning	Cramping	Dull	Numbness
Sharp	Shooting	Spasm	Soreness	Stiff
Stinging	Throbbing	Tingling	OTHER:	_____

Indicate(X or circle) on diagram the pain location:



I **UNDERSTAND** and **AGREE** to authorize Dr. Miller and his employees to administer any examination procedures and treatments as they deem necessary.

Signature _____**DATE** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and can be provided with a copy *HIPAA Notice of Patient Privacy Policy* that provides a more complete description of information uses and disclosures.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will use or disclose health information to carry out treatment, payment, or health care options.
- We will let you know promptly if a breach
- We must follow the duties and privacy practices described in this notice and give you a copy of it upon requested.
- We will not use or share your health information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time/ Let us know in writing if you change your mind.

_____ _____

Patients Signature Date

_____ _____

Parent or guardian Signature *Date*

Parental/Guardian Consent for Minor Patient

Minor Patient Name:_____ Minor Patient age:_____

Name of Child/ Minor: _____

Name of Parent/ Guardian:_____

_____ _____

Parent or guardian Signature **Date**

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor(s) at Miller Chiropractic and whom ever they designate as assistants to administer care to child.

Name of Child/ Minor: _____

Name of Parent/ Guardian:_____

_____ _____

Parent or guardian Signature **Date**

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Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE Doctors (Dr. Kent Miller) at Miller Chiropractic TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____

Patients Signature Date

_____ _____

Parent or guardian Signature Date