MILLER CHIROPRACTIC CENTER

KENT MILLER, D.C. www.millerchiropractic.org **3504 Davis St**
FAX:855-460-7005 PHONE:936-788-6565 **Conroe,TX 77304**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Protection* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes and,
- The right to request restriction as to how my health information maybe used or disclosed to carry out treatment, payment, or health care options.

_____ _____

PRINT NAME Relationship to PATIENT/SELF

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

HIPAA Consent Form

The health insurance Portability and Accountability Act of 1996(HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment,or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health information regarding treatment, payment, or health care operations, in order to provide health care that is your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your health information, but this must be done in writing. Under this law, we have the right to refuse to treat you if should choose to refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Office Manager. You have the right to review our privacy notice, to request restrictions and revoke consent in writing

_____ _____

Patients or Guardian **Signature** Date

Patient Information

PLEASE FILL OUT THE FOLLOWING FORMS AS COMPLETE AS POSSIBLE. ALSO, PLEASE PROVIDE A COPY OF YOUR DRIVER'S LICENSE OR VALID PICTURE ID AND INSURANCE CARD TO FRONT DESK. THANK YOU

Name: _____

SSN:_____ Driver's License #:_____ DOB:_____/_____/_____ Gender: Male Female

Address:_____

City/STATE/ZIP:_____Phone #: Home cell_____

Employment (job): _____

Email (please Print):_____

Who referred you? _____

Marital status: Divorced Married Separated Single Widow **Patient Type**: Self Insurance PIP Auto Accident

Patient's state current problem and start date?_____

_____

_____

_____

Have you lost any time from work? Yes No Do you need a note for work? Yes No

Have you seen any other doctors for this condition? Yes No

Who?_____Phone:_____

Prior Injuries _____

For Females: Are you pregnant? Yes or No Do you take birth control pills?_____

Do you have a **Pacemaker** or **defibrillator**? _____

List any conditions, tests or exams in **last 10 years** we should know about. (Surgeries,falls,head injuries,broken bones,dislocations,etc.)_____

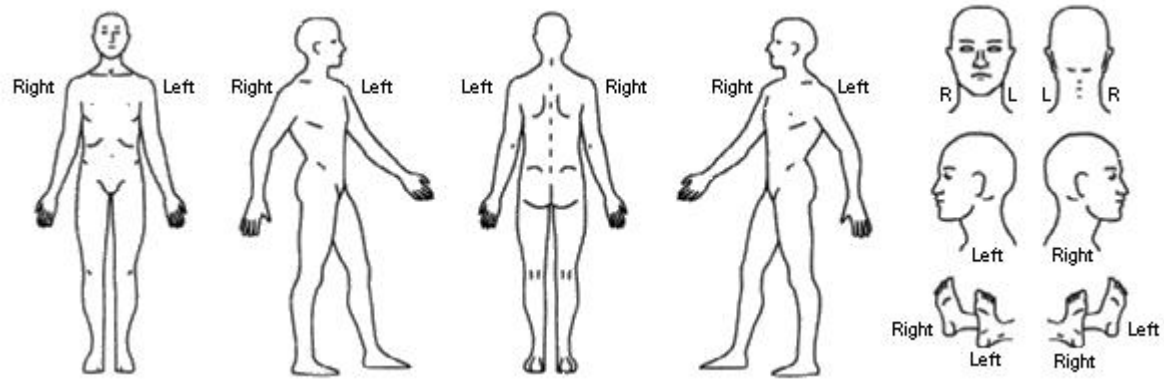
_____

_____

Choose those that apply to you

	Abdominal		Depression		Kidney Disease		Sciatica
	Alcoholism		Diabetes		Liver disease		Short of breath
	Allergy		Dizziness		Mental disease		Sinus trouble
	Anemia		Gall bladder		Migraines		Sleeplessness
	Arthritis		Gout		Multiple sclerosis		Stress
	Asthma		Gynecological		Nausea		Stroke
	Cancer		Headaches		Neck pain		Thyroid problems
	Cataracts		Hearing Trouble		Osteoporosis		Tumors, Growths
	Chest pain		Heart disease		Parkinson's disease		Ulcers
	Cold hands/feet		Hemorrhoids		Polio		Varicose veins
	Colds/infections		Hardening of arteries		Poor appetite		Vision problems
	Colon trouble		Hepatitis		Prostate		Poor appetite
	Constipation		Herniated Disc		Rheumatoid		Weight Gain/Loss
	Concussion		High Cholesterol		Scarlet fever		Whooping cough

Pain Location & Description



*Place a X on each of complaint on the pictures above:

Please **describe** what you think might have caused your complaints:

_____

_____

***Complaint 1:** _____ **Radiating**? Yes or No _____
(*pain location*) (*to what area*)

Describe the pain: (*please circle one or more that apply*): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

How often is this pain occurring? (*please circle one*): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

Current Severity: (*please circle one or more that apply*): mild, mild-moderate, moderate, moderate to severe, severe

***Complaint 2:** _____ **Radiating? Yes or No** _____
(*pain location*) (*to what area*)

Describe the pain: (*please circle one or more that apply*): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

How often is this pain occurring? (*please circle one*): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

Current Severity: (*please circle one or more that apply*): mild, mild-moderate, moderate, moderate to severe, severe

***Complaint 3:** _____ **Radiating? Yes or No** _____
(*pain location*) (*to what area*)

Describe the pain: (*please circle one or more that apply*): aching, burning, cramping, dull pain, numbness, sharp pain, shooting pain, spasm, stiffness, throbbing or tingling?

How often is this pain occurring? (*please circle one*): constant (100% - 75%), frequent (74% -50%), occasional (49% - 1%)

Current Severity: (*please circle one or more that apply*): mild, mild-moderate, moderate, moderate to severe, severe

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

_____ _____
Patient/ Guardian Signature Date