Dr. Jarem Miller
105 West Main Street
Rexburg, Idaho 83440
(208) 356-6772

Patient Information

First Name: _____
Middle Initial: _____
Last Name: _____
Called Name: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Billing Address: same other _____
Cell Phone: _____
Emergency Contact: _____
Emergency Phone: _____
Email Address: _____
Marital Status: Single Married Other _____
Birth Date: _____
Social Security: _____
Reason for Visit:

Insured's Information

Insurance Company: _____
Patient is to insured:
Same/Self Husband Wife Child Other of Insured
First Name: _____
Middle Initial: _____
Last Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Social Security: _____
Date of Birth: _____
Sex: Male Female
How did you find us:_____
Work Status: -Employed - Full-time student
-Part-time Student

_____
_____
_____

CONSENT FOR TREATMENT

Insurance Assignment and Release – By signing below, I authorize Rexburg Chiropractic Center to release medical records required by my Insurance company(ies) and collections. I authorize my insurance company(ies) to pay benefits directly to Rexburg Chiropractic Center. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, office fees or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency, no show and attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and healthcare operations.

By signing below, I give my consent for examination and the performance of any test or procedures needed. If a patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient.

Signed_____ Date_____

Date	Notes

Patient Data Sheet

Sex: Male Female

Smoking Status (circle only) - Current Every Day Smoker - Current Some Day Smoker - Former Smoker

-Never Smoked

Smoking Start Date _____ End Date _____

In an effort to quit smoking, I am currently taking: _____

Do you have any allergies to medication? Yes No

If yes, please indicate the following:

Start Date: _____
End Date: _____
Allergy: _____
Reaction: _____

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End Date: _____
Allergy: _____
Reaction: _____

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End Date: _____
Allergy: _____
Reaction: _____

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End Date: _____
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Reaction: _____

Are you taking any medications? Yes No
If Yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
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Medication
Route: Oral
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B

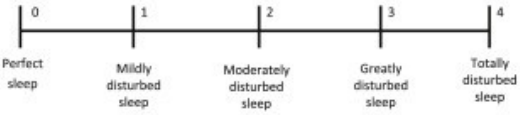
Functional Rating Index

Four use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much **your neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1.Pain intensity

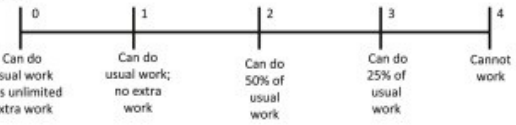
2. Sleeping



3. Personal care(washing, dressing, etc.)

4. Travel (driving, etc.)

5. Work

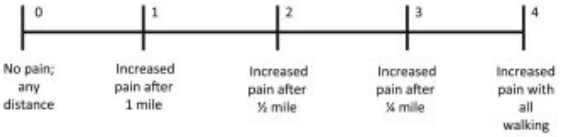


6. Recreation

7. Frequency of pain

8. Lifting

9. Walking



10. Standing