Dr. Dana Miller
105 West Main Street
Rexburg, ID 83440
208-356-6772

PATIENT INFORMATION

NAME: First_____ MI ____ Last_____DOB_____

ADDRESS: _____ City/State/Zip _____

PHONE _____ Sex ___M ____F Marital Status ____S ____M ____ D ____ W

Employer_____ Phone # _____ Occupation _____

Spouse/Parent Name _____ Referred By _____

Emergency Contact _____ Phone # _____ Relationship _____

Reason for Visit/How long have you had symptoms _____

_____Cash Account or ____Insurance Ins. Company Name: _____

Responsible Party _____ Self ____ Other If Self - Stop Here If Other - fill out portion below

Name of Responsible Party: _____ DOB: _____ Relationship _____

Phone # _____ Mailing Address (if different) _____

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). 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 or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or 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 health care operations.

By signing below, I give my consent for examination and the performance of any tests 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

General Information

First Name _____
Middle Initial _____
Last Name _____

Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

For Office Use Only
Account Number _____
Patient Height _____
Patient Weight _____
Patient BMI _____
Patient Blood Pressure _____

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino

Preferred Language _____
Email Address _____

Smoking Status (circle only 1) Current Every Day Smoker
Current Some Day Smoker
Former Smoker
Never Smoker
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:

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

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

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

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

Are you currently taking any new medication since your last visit? Yes No
If Yes, please indicate the following:

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

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

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