Miller Clinic
400 Lem Morrison Drive
Auburn University, AL 36849
Phone: 334-844-7651 Fax: 334-844-6245

PATIENT INFORMATION

Name:_____ Date of Birth: _____/_____/_____
Last First Middle

Address:_____ Social Security #:_____-_____-_____

City: _____ State:_____ Zip:_____ Sex (circle one): M F Email Address:_____

Cell Phone: (_____)_____ Home: (_____)_____ Work: (_____)_____

Emergency Contact- Name: _____ Relationship:_____

Cell Phone: (_____)_____ Home: (_____)_____ Work: (_____)_____

Address: _____
Street City State Zip

PAST SURGERIES AND DATES

_____
_____
_____

ALLERGIES

_____
_____
_____

CURRENT MEDICATIONS, DOSE, AND FREQUENCY

_____
_____
_____

SOCIAL HISTORY

Drink Alcohol:	Yes ☐	No ☐	# per week: _____
Smoke:	Yes ☐	No ☐	# of Years:_____
Smokeless Tobacco:	Yes ☐	No ☐	
Recreational Drugs:	Yes ☐	No ☐	Drugs used:_____

PERSONAL/FAMILY HISTORY:

PH= Personal History FH=Family History

*****please use empty box to provide any specifications (type of cancer/family member etc.)***

Arthritis	PH FH	
Autoimmune Disease	PH FH	
Diabetes	PH FH	
Cancer	PH FH	
Neurologic Disorder	PH FH	
Heart Condition	PH FH	
Migraines	PH FH	
Stroke	PH FH	
Infectious Disease	PH FH	
Other_____	PH FH	

Patient Name:_____
Height: _____ Weight: _____

PRIMARY COMPLAINT (Please Describe):

_____
_____
_____
_____
_____
_____

DOES THE PAIN COME AND GO? ☐ Yes ☐ No

HOW LONG HAS IT BEEN OCCURING? _____

Check *ALL* that aggravates your symptoms

Bending ☐ Sleeping ☐
Breathing ☐ Standing ☐
Coughing ☐ Walking ☐
Driving ☐ Working ☐
Exercising ☐ Other _____
Sitting ☐ Other _____

Check *ALL* that relieve your symptoms

Chiropractic ☐ Rest ☐
Ice ☐ Sitting ☐
Massage ☐ Standing ☐
Medication ☐ Other_____
Other _____

SECONDARY COMPLAINT(s) :

_____
_____
_____
_____
_____

HOW LONG HAS IT BEEN OCCURING? _____

Check ALL that aggravates your symptoms

Bending ☐ Sleeping ☐
Breathing ☐ Standing ☐
Coughing ☐ Walking ☐
Driving ☐ Working ☐
Exercising ☐ Other _____
Sitting ☐

Check ALL that relieve your symptoms

Chiropractic ☐ Rest ☐
Ice ☐ Sitting ☐
Massage ☐ Standing ☐
Medication ☐ Other_____

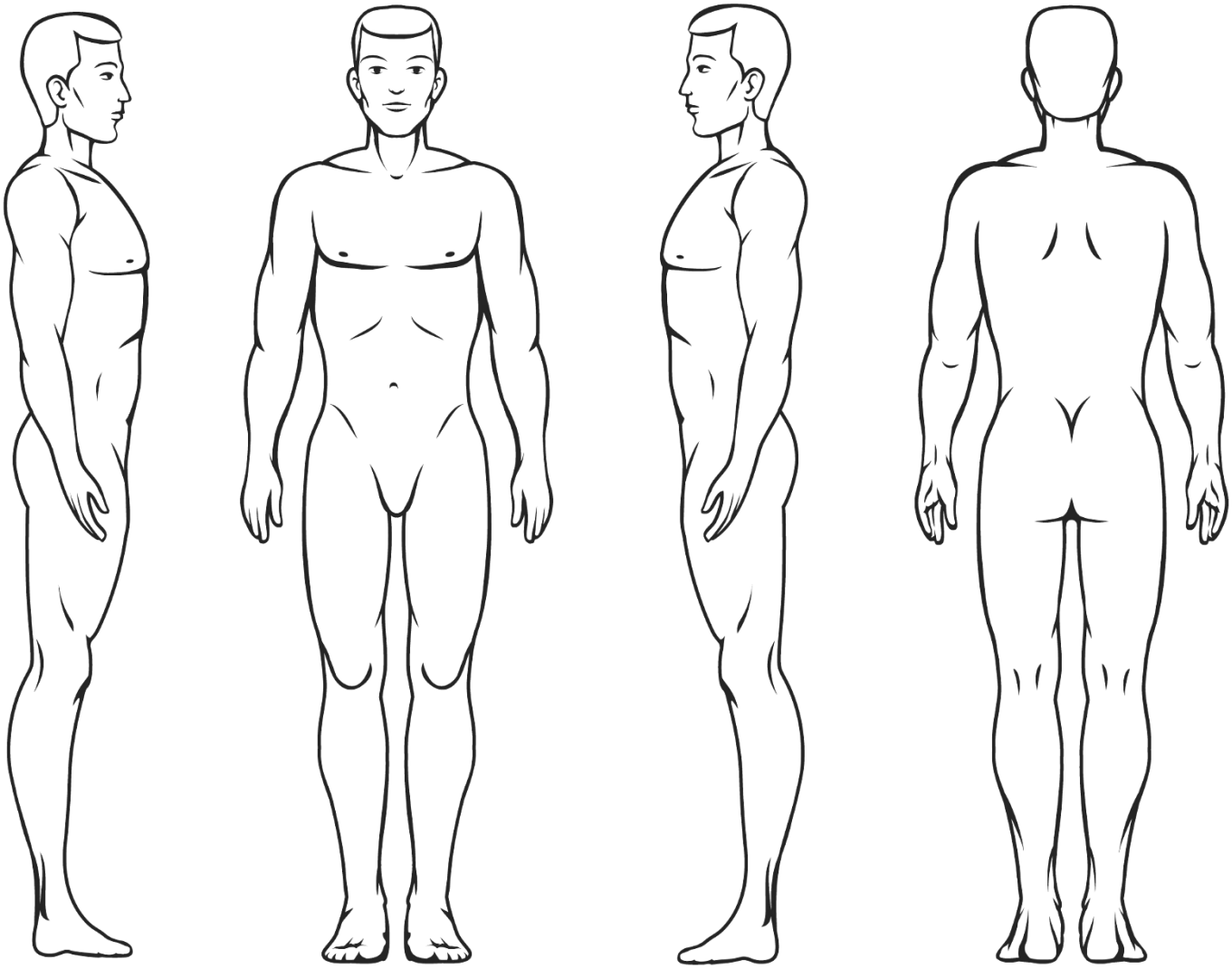
PLEASE USE THE DIAGRAM(s) BELOW TO INDICATE WHERE AND WHAT KIND OF PAIN YOU ARE HAVING

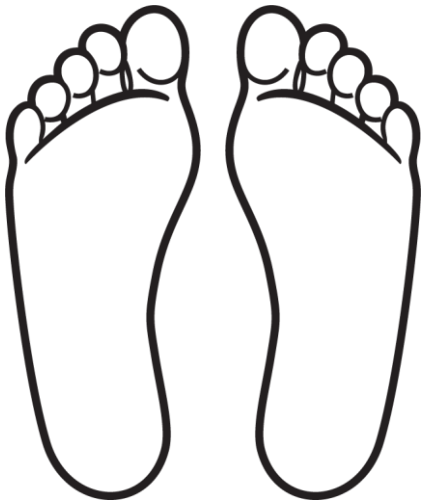
A=Aching B=Burning D=Dull F=Stiff G=Tight N=Numb

P=Pins & Needles S=Stabbing T=Throbbing O=Other_____

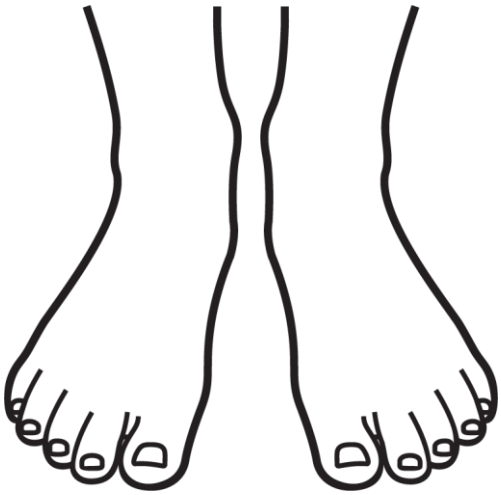
Please rate your level of pain on the following scale

(no pain) 1 2 3 4 5 6 7 8 9 10 **(worst pain imaginable)**





Right **Left**



Right **Left**

Please read the following consents carefully and sign where indicated. ***Please note there are 3 sections that require a signature***

Authorization for Medical and Diagnostic Treatments

(1) I wish to receive treatment at The Miller Clinic. While I am at The Miller Clinic, I permit my doctor, The Miller Clinic and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. (2) The Miller Clinic sometimes serves as a training center for students in a variety of different health care professions. Students will sometimes be allowed to observe procedures which would benefit their educational experience. I do not object to students observing my care, treatment or procedures performed upon me. (3) I understand that medical equipment/supply company representatives will sometimes be present during a procedure to instruct medical personnel on new equipment or supplies. I do not object to these representatives being present during my care, treatment, or procedures performed upon me. (4) I understand that photographs or films may be taken during the course of my treatment to be made a part of my medical record. I do not object to the taking of these photographs or films.

Release of Medical Information

I, the undersigned as the patient or his/her authorized representative, authorize The Miller Clinic and any other professionals who provided care, treatment or services to release to my insurance company (ies) or their authorized representative or other appropriate agency (ies) that information which is necessary to validate this claim for payment purposes. This includes my employer if workers' compensation is claimed. The Miller Clinic is also authorized to release to my physician(s), or the persons authorized to bill for them, such information as necessary for billing purposes, including, without limitation, all records and information pertaining to my medical treatment (including that for drug & alcohol abuse), laboratory & other diagnostic tests results, x-rays, therapy, diagnoses and prognosis. In the event that I am transferred to another healthcare facility, I authorize The Miller Clinic to make a copy of my medical records for the receiving healthcare facility.

Release of Responsibility for Loss of Valuables

I understand that The Miller Clinic will not be responsible for valuables, including jewelry, watches, money, etc., not specifically placed in the care of The Miller Clinic through proper procedures. I also understand that The Miller Clinic cannot be responsible for personal items such as clothing, glasses, dentures, etc., inadvertently damaged or misplaced during my course of treatment. I accept full responsibility for those valuables or personal items which I choose to keep in my possession.

Patient's Signature: _____ Date: _____ or their

Authorized Representative: Relationship_____
If the patient or their authorized representative is unable to sign, state the reason why here: _____

Assignment of Insurance and Financial Responsibility

I authorize payment of all insurance benefits, basic and major medical, for this period of medical, emergency and/or diagnostic treatments, to be made directly to The Miller Clinic I understand that I am financially responsible for all charges not covered by my insurance plan, including but not limited to co-pays, deductibles, non-covered charges, professional fees and nurse practitioner professional fees. All efforts for collection of the benefits are for my convenience and do not represent a guarantee for collection or a credit to my account until such time as payment is received by The Miller Clinic. I also assign the benefits payable for physicians' services to the physicians(s) furnishing the services, or authorize such physicians or physician group to submit a claim to my insurance company(ies). I will be responsible for any collection fees, court cost and/or attorney fees incurred by The Miller Clinic or any physician participating in my care while collecting on my account(s). Failure to comply by these financial policies and/or recurring instances of collection activity could result in dismissal from the practice. Photocopies of this authorization are as valid as the original. I authorize The Miller Clinic, its employees and agents to contact me at any/all phone numbers (including cell phone numbers) for the purpose of treatment, insurance and payment. I acknowledge that I may be contacted by telephone at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. I also may be contacted by text messages or emails, using any email address that is provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices. By my admission to The Miller Clinic, I acknowledge that I am entering into a credit transaction as defined under The Fair Credit Reporting Act 15 U.S.C.§ 1681and that The Miller Clinic may, with or without my knowledge, obtain a consumer credit report for all permissible purposes, including, but not limited to, debt collection activities and use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status.

Patient's Signature: _____ Date: _____ or their

Authorized Representative: Relationship _____

Acknowledgment of No-Show Policy

Any patient's appointment considered missed or "no-show" will incur a **$25.00** fee per incident. If you, as the patient, are unable to keep the scheduled appointment, please contact The Miller Clinic at least 2 business days before the scheduled appointment. If the patient fails to notify The Miller Clinic of their inability to keep the scheduled appointment at least 2 business days in advance, the **$25.00** "no-show" fee will be applied to their account.

Patient's Signature: _____ Date: _____ or their

Authorized Representative: Relationship _____