PERSONAL HEALTH INFORMATION

Please allow our staff to verify a photo ID and photocopy your insurance details. All information you supply is confidential. We comply with all federal privacy standards.

Dr. Kay Miller
435 S. Main St.
Fond du Lac, WI 54935
Phone: 920-933-3536
FAX: 920-933-3538

TODAY'S DATE _____

Your Last Name _____ **Your Social Security Number** _____ **Birth date** _____ **Age** _____

Your First Name _____ **Your Middle Name or initial** _____ **GENDER** ◯ **Male** ◯ **Female** **Race** _____

Address _____ **Marital Status** ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Widowed** ◯ **Separated** **Ethnicity** _____

City _____ **State** _____ **ZIP Code** _____ **Preferred Language** _____

Home Phone _____ **Cell Phone** _____ **Cell Carrier** _____

Email address _____ **Work Phone** _____

Emergency Contact/relationship _____ **Emergency Contact Phone** _____ **Spouse's name** _____

Your Employer _____ **Your Occupation** _____

Address _____ **May we contact you at work?** ◯ **Yes** ◯ **No**

City _____ **State** _____ **ZIP Code** _____ **Preferred method of contact** ◯ **Home Phone** ◯ **Cell Phone** ◯ **Work Phone** ◯ **Email** ◯ **Text message**

Primary Care Provider's Name _____

Facility, City _____

Insurance Company _____

May we contact you to remind you of your appointments? ◯ **No** ◯ **Yes, prefer** ◯ **Phone** ◯ **Email** ◯ **Text** (we need your cell carrier info)

May we discuss your insurance/financial information and/or appointment/treatment information with your family members?
Whom? ◯ Spouse ◯ Parent ◯ Adult Child **Which information?** ◯ All ◯ Insurance/Financial ◯ Appts. ◯ Treatment

Whom may we thank for referring you? _____

Have you consulted a chiropractor before? ◯ No ◯ Yes When and whom? _____