|  |  |  |  |
| --- | --- | --- | --- |
| NAME | DATE OF BIRTH | AGE | SEX:MALEFEMALE |
| ADDRESS & STREET | PHONE NUMBER: |
| CITY, STATE, ZIP | ALTERNATE NUMBER: |
| MARITAL STATUS* Married
* Widowed
* Divorced
* Single
 | NUMBER OF CHILDREN: | AGES: | SPOUSE’S NAME: |
| OCCUPATION: | EMPLOYER: | WORK PHONE NUMBER: |
| EMERGENCY CONTACT RELATIONSHIP PHONE NUMBER |
| **REFERRED BY:** | **HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE?**YES / NOIF YES: WHERE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LAST ADJUSTMENT?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **IS YOUR VISIT DUE TO A RECENT AUTO ACCIDENT OR JOB INJURY/WORKERS COMP CASE FOR WHICH YOU HAVE AN ACTIVE CLAIM?**YES / NO |
| **DO YOU HAVE HEALTH INSURANCE?** |

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| **REASON FOR TODAY’S VISIT? EXAMPLE: NECK PAIN, LOW BACK PAIN, HEADACHE, ETC:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**IS THIS BEING TREATED BY ANY OTHER PHYSICIANS?** YES / NO PRIMARY CARE PHYSICIAN NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **HAVE YOU EVER HAD ANY FALLS, AUTOMOBILE ACCIDENTS OR INJURIES?**YES / NO | MONTH/YEAR: | TYPE OF ACCIDENT | PLEASE DESCRIBE INJURY |
| **HAVE YOU EVER HAD A SURGERY?**YES / NO | MONTH/YEAR: | TYPE OF SURGERY | COMMENTS |
| **ANY PRESENT OR PRIOR ILLNESS?**YES / NO | MONTH/ YEAR: | TYPE OF ILLNESS | COMMENTS |
| **ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR SUPPLEMENTS?**YES / NO | NAME OF MEDICATION: DOSAGE PER DAY:NAME OF MEDICATION: DOSAGE PER DAY:NAME OF MEDICATION: DOSAGE PER DAY: |
| **IS IT POSSIBLE YOU COULD BE PREGNANT?** YES / NO |

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| --- |
| **FAMILY HISTORY OF ILLNESS: PLEASE INDICATE RELATIONSHIP, ILLNESS, AND AGE OF DEATH IF APPLICABLE. EXAMPLES: DIABETES/HEART ATTACK/CANCER**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ANY ALLERGIES TO ANY MEDICATIONS? IF SO PLEASE LIST BELOW:**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**INSURANCE AND PAYMENT POLICIES:**

* All estimated co-pays/coinsurance amounts are due at the time of service.
* Royek Family Chiropractic must be notified of any primary or secondary insurances before initial treatment. It is the patients responsibility to update insurance as necessary.
* All products and services not covered by insurance must be paid in full at the time of service.
* All services that are subject to a deductible will be billed to insurance. Once the insurance carrier has processed the claim, any balance owed must be paid in full upon receipt of statement.
* Any disputed balances will be reviewed by our billing service. Once the balance has been confirmed, the balance owed must be paid in full upon receipt of statement.
* We will attempt to confirm all insurance benefits prior to your visit. If for any reason benefits cannot be confirmed, cash fees will apply. NOTE: Benefits for some out of state plans will not be able to be confirmed at time of service. If you have an out of state policy, please review your benefits prior to the date of service before any treatment.
* In cases where an insurance carrier’s fee schedule cannot be determined, all estimated coinsurance amounts will be based on our full fees.
* If you have used all your insurance benefits for your policy year, you will have the option of paying our current cash fees, purchasing a prepaid care package, or paying the participating provider rate as determined by your insurance provider.
* If patient payment is not received within 90 days of the service date the balance may be sent to collections upon doctor’s discretion.

**AUTHORIZATION, ASSIGNMENT, ACKNOWLEDGEMENT AND UNDERSTANDING**

**RELEASE OF INFORMATION**: I hereby authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Royek Family Chiropractic and hereby release you of any consequences thereof.
**ASSIGNMENT OF PAYMENT**: I hereby instruct and direct my insurance company to pay by check made out and mailed directly to Royek Family Chiropractic the professional and/or medical benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by Royek Family Chiropractic. Further, it is understood that I, the undersigned agree to be financially responsible for all charges incurred at Royek Family Chiropractic including my insurance deductible, copayment and any services (ex. Traction, Manual Therapy, E-STIM, Laser Therapy) reflected by my insurance company.

**ACKNOWLEDGEMENT OF PROTECTED HEALTH INFORMATION PRACTICES**: It is understood that by Federal Law, my personal health information is protected. Royek Family Chiropractic has available for review its HEALTH PRIVACY POLICY regarding the sharing of that information. Should I have any questions regarding this policy, I will contact the office at *734-433-1376*.

**TERMS OF ACCEPTANCE**: It is understood that the chiropractic care received in this office is not meant to diagnose or treat any disease or condition other than vertebral sublxation.

PRINT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WITNESS SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE OR CHECK ANY OF THE FOLLOWING THAT CURRENTLY GIVE YOU DIFFICULTY OR HAVE IN THE PAST:**

|  |  |
| --- | --- |
| * Headaches
* Shooting head pains
* Sinus trouble
* Loss of smell
* Allergies/Hay fever
* Loss of taste
* Inflammation of throat
* Thyroid trouble
* Twitching of face
* Loss of memory
* Fatigue
* Depression
* Dizziness
* Cold hands/fingers
* Shortness of breath
* Heart attacks
* High blood pressure
* Low blood pressure
* Anemia
* Stomach trouble
* Nervousness
* Irritability
* Gall bladder trouble
* Indigestion
* HIV/AIDS
* Rheumatoid arthritis, psoriatic arthritis
 | * Low back pain
* Mid back pain
* Neck pain
* Grinding in neck
* Pain in shoulders/arms
* Pins & Needles in arms/hands
* Pain in legs or feet
* Pins & Needles in legs/feet
* Fainting
* Loss of balance
* Ringing in ears
* Blurred vision
* Lights bother eyes
* Muscle spasms
* Earache
* Ulcers
* Constipation
* Incontinence
* Menstrual cramps/pain
* Menstrual irregularity
* Diabetes
* Cancer
* Sleeping problems
* Swollen ankles
* Cold feet
* Intestinal gas
* Kidney trouble
 |
| **PLEASE INDICATE THE ACTIVIES OF DAILY LIVING CURRENTLY AFFECTED BY YOUR PRESENT COMPLAINTS: PLEASE CIRCLE OF CHECK ANY THAT MAY APPLY** |
| * Walking
* Sitting
* Climbing stairs
* Getting up from a seated position
* Kneeling
* Sleeping/lying in bed
* Standing
* Lifting
* Getting in/out of bathtub
* Doing laundry
 | * Working at a computer
* Swimming
* Shopping
* Running
* Bending
* Yardwork
* Driving or riding in a car
* Exercise
* Getting in/out of car
 |