Royek Family Chiropractic

Name	Date of birth	Age	Sex: ☐Male ☐Female
Address & Street		Phone Number:	
City, State, Zip		Alternate Number:	
Marital Status ☐Married ☐Widowed ☐Divorced ☐Single	No. of Children	Ages	Spouse's Name
Occupation	Employer	Work Phone Number	
E-Mail Address			
Emergency Contact	Relationship	Phone Number	
Referred by	Have you ever had chiropractic care before? ☐ Yes ☐No If yes: Where? _____ Last Adjustment?_____	Is your visit here due to a recent: ☐Auto Accident ☐ Job Injury/Workers Comp Case	

Reason for Today's Visit	
_____ _____ _____	
Is this issue being treated by any other physicians? ☐Yes: ☐No:	Do you have health insurance? ☐Yes: Primary_____Secondary_____ ☐No
Primary Care Physician:	Is it possible you could be pregnant: ☐ Yes ☐ No

Have you ever had any falls, accidents or injuries? ☐Yes ☐No	Month/Year	Type of accident	Describe Injury
Have you ever had 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:	

For Doctors Use Only:

_____

_____

_____

_____

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_____

_____

_____

Please check any of the following that give you difficulty:

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hayfever
- ☐ Asthma
- ☐ Loss of taste
- ☐ Inflammation of throat
- ☐ Thyroid trouble
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Cold hands/fingers
- ☐ Shortness of breath
- ☐ Mid-back pain
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Nerves and nervousness
- ☐ Inner tension
- ☐ Irritability
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Low back pain
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Lights bother eyes
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Grinding in neck
- ☐ Tightness of shoulders/arms
- ☐ Pain in shoulders/arms
- ☐ Pins & needles in arms/hands
- ☐ Ear ache
- ☐ Numbness in arms/hands
- ☐ Ulcers
- ☐ Numbness in legs or feet
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual cramps and pain
- ☐ Menstrual irregularity
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Pins and needles in legs
- ☐ Swollen ankles
- ☐ Cold feet
- ☐ Pain in legs and feet
- ☐ Intestinal gas

Please indicate the activities of daily living affected by your present complaints

- ☐ Walking
- ☐ Sitting
- ☐ Climbing stairs
- ☐ Getting up from a seated position
- ☐ Kneeling
- ☐ Sleeping
- ☐ Standing
- ☐ Lifting
- ☐ Getting in/out of bathtub
- ☐ Doing laundry
- ☐ Working at a computer
- ☐ Swimming
- ☐ Shopping
- ☐ Running
- ☐ Bending
- ☐ Lying in bed/sleeping
- ☐ Yardwork
- ☐ Riding in a car
- ☐ Exercise
- ☐ Getting in/out of a car
- ☐ Driving

This document is to be completed in office at time of service.

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 reflected by my insurance company.

Acknowledgement of Protected Health Information Practices: It is 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 this office.

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 subluxation.

_____ _____

Patient Name Patient Signature

_____ _____

Date Witness

Royek Family Chiropractic
1307 S. Main St. Suite C
Chelsea, MI 48118
(734) 433-1376
Dr. Matthew Royek, DC
Dr. Katherine Royek, DC

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Insurance and Payment Policies

- All estimated co-pays/coinsurance amounts are due at the time of service
- 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.
- 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 of 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.

I have read and understand the above policies:

_____ _____

Patient Name Patient Signature

_____ _____

Date Witness

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(734) 433-1376
Dr. Matthew Royek, DC
Dr. Katherine Royek, DC

Royek Family Chiropractic

Patient Name:_____ Date Of Birth:_____/_____/_____

Medications:

_____
_____
_____
_____
_____
_____
_____

Allergies to any medications? Yes or No

If yes, please list below:

_____
_____
_____

Other Allergies?

_____
_____

Language:_____

Ethnicity:_____

Gender: Male or Female

Race:_____

Smoking Status: Current smoker Non-Smoker

Have you ever smoked? Yes or No

FOR DOCTORS USE ONLY:

- BP_____/_____ Left or Right
- Height_____ Weight:_____BMI:_____
- Pulse_____

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