

VIDEYKO CHIROPRACTIC
 128 STATE STREET
 NEWBURYPORT, MA 01950
 (978) 465-1500

A. PATIENT INFORMATION (Please Print)

PATIENT'S NAME				NICKNAME			
STREET ADDRESS			CITY		STATE	ZIP	
MAILING ADDRESS (if different)			CITY		STATE	ZIP	
DATE OF BIRTH / /	SOCIAL SECURITY #		HOME PHONE		ALTERNATE PHONE		
GENDER (circle one) MALE / FEMALE			MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER <input type="checkbox"/>		SPOUSE'S NAME		
HOW DID YOU HEAR ABOUT US?		PHYSICIAN / M.D. (please include address or phone#)			May we send a report of our findings to your Physician? Yes <input type="checkbox"/> No <input type="checkbox"/>		
PERSON TO CONTACT IN EMERGENCY			RELATIONSHIP TO YOU		PHONE		

B. EMPLOYER INFORMATION

EMPLOYER NAME		EMPLOYER ADDRESS: STREET, CITY, STATE		OCCUPATION	
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER NAME		SPOUSE'S EMPLOYER ADDRESS: STREET, CITY, STATE	

C. INSURANCE INFORMATION (If no insurance, skip this section)

INSURED'S NAME <input type="checkbox"/> Self <input type="checkbox"/> Other, relationship _____ or, if SELF, check box and skip to next section.		INSURED'S SOCIAL SECURITY #			
INSURED'S STREET ADDRESS		CITY		STATE	ZIP
INSURED'S EMPLOYER			INSURED'S DATE OF BIRTH		

Copy of card on file (if checked, skip next section)

INSURANCE NAME and ADDRESS (claims mail to address)		
GROUP NAME	GROUP (PLAN) #	POLICY ID #

To receive our monthly e-mail newsletter – e-mail address: _____

**** IF THIS IS AN AUTO OR WORK-RELATED ACCIDENT –
PLEASE SEE THE FRONT DESK FOR ADDITIONAL REQUIRED PAPERWORK.**

I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for services rendered not to exceed the reasonable and customary charge for those services.

I hereby authorize the attending physician to release any information acquired in the course of my examination and treatment to insurance or other paying authorities. Read, understood and accepted.

SIGNED _____

DATE _____

Welcome to Videyko Chiropractic Office

The following information is to help you understand the billing and financial policies of the office.

Third Party Payers	<p>If you have health insurance, we will help you determine if your insurance company covers chiropractic care and to what extent. <i>Your insurance coverage is a contract between you and your insurance company, so you will be responsible for services that you receive and are not covered by your plan.</i></p>
Covered by Workers' Compensation or Automobile Insurance	<p>If you are being treated for injuries that were the result of a work-related accident or an automobile accident, please let us know <u>immediately</u>. These are generally 100% covered. We will need to have very specific paperwork completed in order for your insurance coverage to be accepted by this office.</p>
Medicare	<p>Dr. Videyko is a participating Medicare provider. This means that the doctor will submit your bills and accept assignment for all covered services. Medicare recipients must present their enrollment card at the onset of treatment. Patients are required to pay Medicare Co-payments, deductibles and all non-covered services. Manipulation is the only service covered by Medicare. If your condition requires other services not covered by Medicare, you will be asked to pay for these at the time of service. Patients are responsible for notifying Medicare of any supplemental coverage.</p>
Private Pay	<p>If you do not have insurance coverage, we have a pre-payment plan that will help you save money and receive the chiropractic care that you need. <i>You may also pay per visit.</i></p>
Changing or Canceling an Appointment	<p>If you need to change or cancel an appointment, we ask that you please give us a 24-hour notice so that we may offer that appointment time to someone else who is in need. Failure to do so will result in a \$25 missed appointment charge to your account.</p>

We do expect payment to be made at the time of service and there will be a \$15 charge for any returned checks.

I have read and understand the information presented above.

Patient

Date

092500

NAME: _____

DATE: _____

CONSULTATION BY: DR. Robert Videyko, D.C.

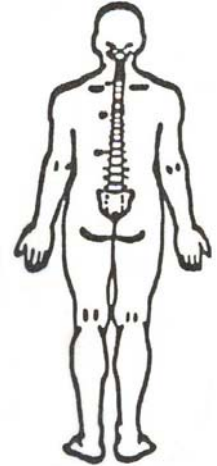
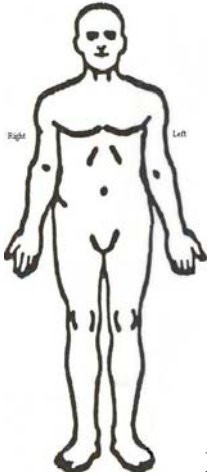
Please rate your average intensity of symptoms/pain = 0 (none) to 10 (unbearable)



MAJOR COMPLAINTS

1. _____
2. _____
3. _____

HISTORY (that pertains to complaints)



Rt Lt

Lt Rt

1. Can you relate this to an accident? _____ strain? _____ fall? _____
2. First aware of the problem this time? _____
3. Ever had similar condition in the past? _____
4. What type of pain/describe? _____
5. Seen any other Dr. for this problem? _____
6. Result/diagnosis/treatment? _____
7. What, if anything, provides relief? _____
8. What makes it worse? _____
9. Symptoms increased by standing? _____ sitting? _____ walking? _____
lying? _____ bending? _____ coughing? _____ sneezing? _____
10. Does rest affect symptoms? _____
11. Any previous falls, accidents? _____
12. Was surgery ever recommended? _____
13. Normal sleeping posture? _____
14. Do you work seated? _____ standing _____ bending? _____ lifting? _____
15. Any sports or vigorous exercise? _____
16. Hereditary possibilities? _____
17. Blood test recently? _____ Results? _____
18. Comments _____