Patient Registration

Please PRINT and complete ALL sections below

1.Patient Information

Name:_____
Last **First** **Middle Initial**

Date of Birth: _____/_____/_____ **Social Security No:** _____-_____-_____

Sex: □ **Female** □ **Male** **Marital Status:** □ **Single** □ **Married** □ **Widowed** □ **Divorced**

Residence Address: _____ **Home Phone : ( )**_____

_____ **Cellular/Pager: ( )**_____

Mailing Address: _____

_____

Previous Military Service? □ **No** □ **Yes Branch:** _____**Rank:**_____ □ **Active** □ **Reserve** □ **Retired**

Employer:_____

Employer's Address: _____ **Work Phone: ( )**_____

_____ **Employment Status:** □ **Full Time** □ **Part Time**

□ **Retired** □ **Not Employed**

Occupation: _____

If Student, Name of School: _____ **Student Status:** □ **Full Time** □ **Part-Time**

2. Spouse Information

Name: _____
Last **First** **Middle Initial**

Date of Birth: _____/_____/_____

Previous Military Service? □ **No** □ **Yes Branch:** _____**Rank:**_____ □ **Active** □ **Reserve** □ **Retired**

Employer:_____

Employer's Address: _____ **Work Phone: ( )**_____

_____ **Employment Status:** □ **Full Time** □ **Part Time**

□ **Retired** □ **Not Employed**

Occupation: _____

3. Guarantor / Responsible Person
(If not covered by insurance)

Name:_____
Last **First** **Middle Initial**

Relation to Patient: □ **Self** □ **Spouse** □ **Other:** _____

If Other – Please complete the following. (Otherwise skip to next section)

Date of Birth: _____/_____/_____ **Social Security No:** _____/_____/_____

Work Phone: ( )_____ **Cellular: ( )** _____ **Home: ( )**_____

Employer: _____

Employer's Address: _____

Occupation: _____ □ **Full Time** □ **Part Time** □ **Retired** □ **Not Employed**

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4. Is your condition the results of an accident? □ **Yes** □ **No** **(If no – Check No and proceed to next section)**

If Yes - □ **Work Injury?** □ **Auto Accident?** □ **Other:** _____

Date of Injury: _____/_____/_____ **Claim No:** _____

Insurance Company: _____

Address: _____

_____

Adjustor/Contact Person: _____ **Telephone No: ( )** _____

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5. Insurance Information (Please present insurance card(s) to receptionist so a copy can be included in your file.)

Primary Insurance: _____ **Insurance ID no:** _____

Name of Insured: _____
Last **First** **Middle Initial**
Relation to patient: □ **Self** □ **Spouse** □ **Other:** _____ **Sex:** □ **Male** □ **Female**

Insured's Social Security No: _____-_____-_____ **Insured Date of Birth:** _____/_____/_____

If the patient is covered by another insurance policy, please complete the following information for coordination of benefit This information ill enable your insurance company to process your claim more quickly. Thank you!

Secondary Insurance: _____ **Insurance ID no:** _____

Name of Insured: _____
Last **First** **Middle Initial**
Relation to patient: □ **Self** □ **Spouse** □ **Other:** _____ **Sex:** □ **Male** □ **Female**

Insured's Social Security No: _____-_____-_____ **Insured Date of Birth:** _____/_____/_____

If the patient is covered by another insurance policy, please complete the following information for coordination of benefit. This information will enable your insurance company to process your claim more quickly. Thank You!

Secondary Insurance: _____ Insurance ID no: _____

Name of Insured: _____

Last First Middle Initial

Relation to patient: □ Self □ Spouse □ Other: _____ Sex: □ Male □ Female

Insured's Social Security No: _____-_____-_____ Insured Date of Birth: _____/_____/_____

6. Patient's Referral Information

Referred by: _____If referred by a friend may we thank him/her? □ Yes □ No

Name of other physician(s) who are taking care of you:

1). _____ 3). _____

2). _____ 4). _____

7. Emergency Contact

Name of the person not living with you: _____

Last First Middle Initial

Relationship: _____ Home Phone: ( ) _____

Address: _____ Work Phone: ( ) _____

_____ Cell Phone: ( ) _____

8. Telephone Messages :

Do you have an answering machine at home: □ No □ Yes May we leave a message on your machine for you? □ No □ Yes

Other instructions regarding leaving messages: _____

_____

Assignment of Benefits / Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Jon F. Graham, M.D. LLC for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize the release of any and all information necessary to secure the payment of benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I further agree that a photocopy of this agreement shall be as valid as the original**.**

Patient's Signature: _____ Date:_____

Insurance and Financial Policy

1. The fees for our professional services are based upon usual and customary charges in this area.

2. We recognize that our patients often must seek medical services when the patient is least able to bear the expense, however, the responsibility for paying for care will be placed upon those who receive services, other than some of the exceptions listed below.

3. If you insurance company does not pay the physician directly, a payment of 20% will be requested at the time of service. We will be happy to discuss our charges with you. If necessary, financial arrangements can be made by discussing this without office management prior to your appointment.

4. We bill all primary insurance companies when billing information and a billing address is provided. We are participating Medicare providers and bill Medicare as well as your secondary insurance company.

5. Patients covered by worker's compensation claims, Medicaid or Quest must provide this office with all necessary information.

    a. We must have current cards on patient covered by Medicaid and/or Quest.
    b. Worker's compensation claims require claim numbers and date of injury as well as mailing address.
    c. Patients who are covered under worker's compensation claims must provide this office with their private insurance information in the event that your claim is denied.
    d. If you cannot provide us with this necessary information for billing, it may be necessary to reschedule your appointment.

6. We do not feel that a liability action against someone else is a reason to delay payment of your bill.

    a. Payment is the responsibility of the individual who has received the treatment, not the individual being sued.

b. For this reason as well as the fact that lawsuits may go on for an extended period of time, we expect our bill to be paid promptly.
c. Without insurance coverage, payment in full will be expected at the time of service, unless other arrangements are made.

7. Past due account will be turned over to an outside collection agency. Patients whose accounts have been assigned for collection may be seen in the future on a cash basis only.

8. Your medical records are held in strict confidence. Information will not be provided to a third party (except a worker's compensation carrier) unless we have current written authorization from you.

    a. Information on patients should be requested in writing and a written authorization from the patient must be included.
    b. Medical record assimilation takes time and we must charge for this. Minimum charge is $40.00 according to time involved.

9. We will be happy to complete disability form for you, however, this also requires time and a nominal charge per form is required prior to information being completed.

    a. As a courtesy we will complete one (1) disability form for you at "No Charge".
    b. All subsequent disability form will be assessed a minimum charge of $25.00 each.

I fully understand the terms of this policy

☐ I accept the terms of this policy
☐ I decline the terms of this policy

Patient's Name: _____

Patient's Signature: _____

Date: _____

Prescription Policy

1. Prescriptions and refills are issued during regular office hours only.
   Monday – Friday – 9:00AM – 4:30PM

2. Dr. Graham does not write prescription or issue refills during the evening and/or weekends when patient's medical records are not available for him.
   Please Plan ahead – Check your need for medications and call during office hours if you need more.

3. **Minimum 24 hours notice for all refills – preferably 48 hours notice.**

4. Restrictions for patients receiving narcotic pain prescriptions from Dr. Graham.

   a. Narcotic pain prescriptions are like currency. They will not be replaced if lost, stolen, flushed down the toilet, eaten by the dog, or whatever.
   b. Prescriptions for narcotic pain medications from other health care providers are not allowed, unless they are covering for Dr. Graham in his absence.
   c. Use only one pharmacy. Do not change your pharmacy without first notifying our office.

5. Please do not call our office to request refill of medications prescribed by other physicians – unless we receive prior notification and authorization directly from the prescribing physician or his authorized staff.

6. Dr. Graham will NOT write prescriptions for pain medications. Prescriptions for pain medication will be deferred to your primary care physician (PCP).

7. Due to electronic prescribing methods, we will now have access to all your medications prescribed by all your physicians.

I fully understand the terms of this policy.

- ☐ I accept the terms of this policy
- ☐ I decline the terms of this policy

Patient's Name: _____

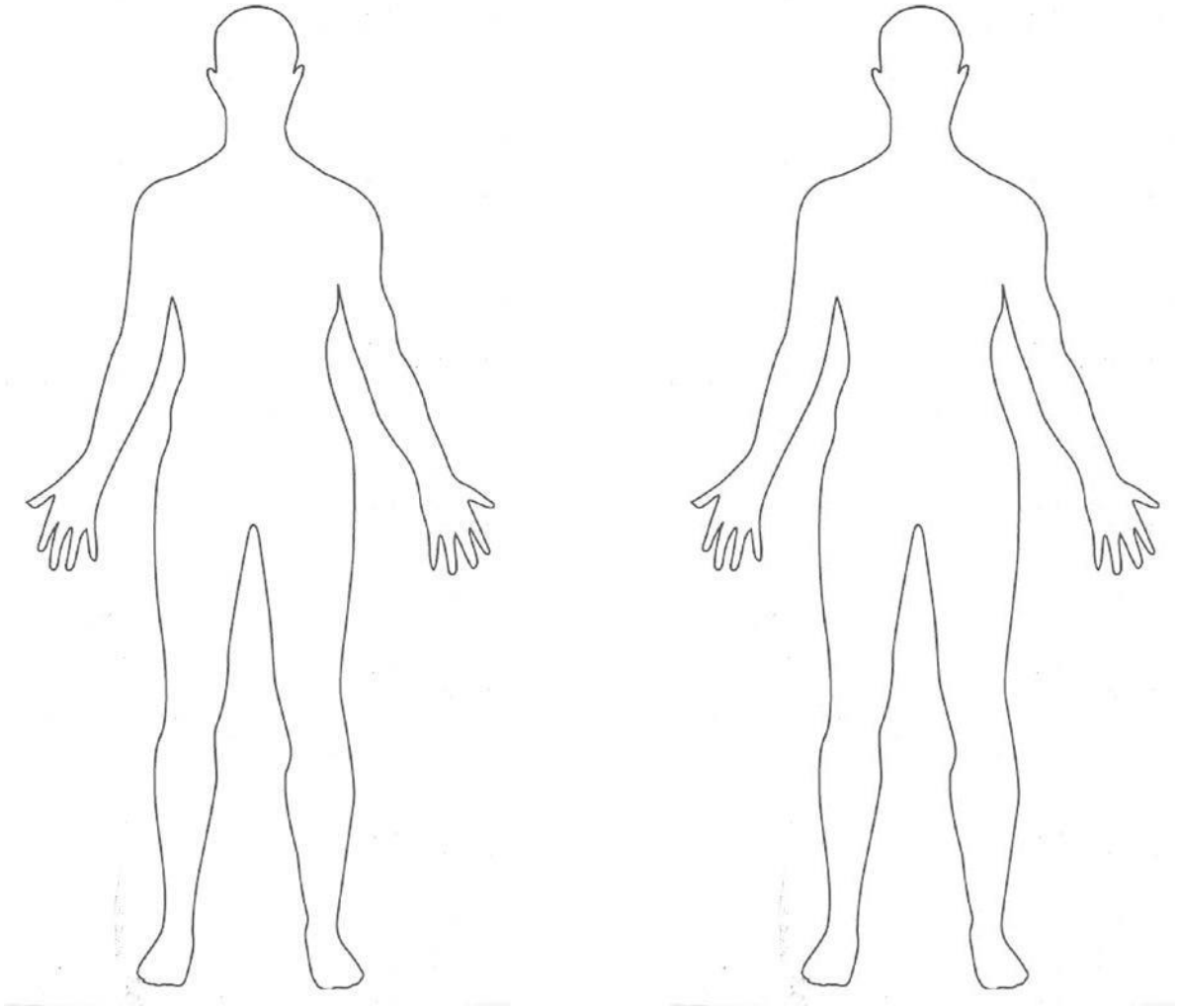
Patient's Signature: _____

Date: _____

Please study the symbols below. Please use appropriate symbols or symbols which best describes your discomfort and place these symbols in the appropriate part of the body outline below to show where the discomfort is.

Aching	**Burning**	**Numbness**	**Pins and Needles**	**Stabbing**
AAAA	**BBBB**	**OOOOOO**	**●●●●●●●●●●●**	**//////////**

Front **Back**



Front **Back**

Rate Your Pain 0= No Pain
10= Extremely Intense Pain

Right Now: 1 2 3 4 5 6 7 8 9 10

At It's Worst: 1 2 3 4 5 6 7 8 9 10 Signed: _____
At It's Best: 1 2 3 4 5 6 7 8 9 10 Date: _____

Patient Health History

Patient's Name: ________ Date of Birth: _____

Chief Complaint:

Referring Physician:

_____

Reason for today's visit?

_____

Describe the symptoms, discomfort and /or problems you are experiencing: _____

_____

_____

_____

_____

_____

Your current problem is the result of (Check all that applies):

[ ] Automobile Accident – Date of Injury _____

[ ] Work Accident – Date of Injury _____

[ ] Personal Injury – Date of Injury _____

[ ] Other: _____

Briefly describe when and how the accident happened: _____

_____

_____

_____

_____

_____

Review of Systems:

Are you currently having or have had problems with:

Constitutional

[ ] Yes [ ] No Fever
[ ] Yes [ ] No Weight Loss
[ ] Yes [ ] No Excessive Fatigue
[ ] Yes [ ] No Night Sweats

Eyes

[ ] Yes [ ] No [ ] Glasses [ ] Contact Lens [ ] Date of last exam:_____
[ ] Yes [ ] No Infections
[ ] Yes [ ] No Injuries
[ ] Yes [ ] No Glaucoma
[ ] Yes [ ] No Cataracts

Ear, Nose, Throat, and Mouth

[ ] Yes [ ] No Hearing Aids Date of Last exam: _____
[ ] Yes [ ] No Hearing Loss
[ ] Yes [ ] No Ear Pain
[ ] Yes [ ] No Ear Infections
[ ] Yes [ ] No Ringing of Ears [ ] Right [ ] Left [ ] Both
[ ] Yes [ ] No Balance Disturbance (e.g. vertigo, spinning)
[ ] Yes [ ] No Nosebleeds
[ ] Yes [ ] No Nasal Congestion
[ ] Yes [ ] No Nasal Drainage Frequency: _____Amount_____ Color: _____
[ ] Yes [ ] No Inability to Smell
[ ] Yes [ ] No Sinus Problems
[ ] Yes [ ] No Sinus Headaches
[ ] Yes [ ] No Sore Throat
[ ] Yes [ ] No Mouth Sores

Cardiovascular

[ ] Yes [ ] No Chest Pain or Angina Date of last EKG: _____
[ ] Yes [ ] No High Blood Pressure
[ ] Yes [ ] No Irregular Pulse
[ ] Yes [ ] No Heart Murmur
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Swelling of Feet and/or Hands
[ ] Yes [ ] No Leg Pain While Walking

Respiratory

[ ] Yes [ ] No Asthma
[ ] Yes [ ] No Chronic Cough
[ ] Yes [ ] No Emphysema
[ ] Yes [ ] No Shortness of Breath
[ ] Yes [ ] No Bronchitis
[ ] Yes [ ] No Pneumonia
[ ] Yes [ ] No Lung Cancer
[ ] Yes [ ] No Bloody Sputum
[ ] Yes [ ] No Chest X-Ray Date of last x-ray: _____

Gastrointestinal

[ ] Yes [ ] No Indigestion of Pain with eating
[ ] Yes [ ] No Nausea
[ ] Yes [ ] No Vomiting
[ ] Yes [ ] No Blood in your vomit
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Jaundice
[ ] Yes [ ] No Abdominal Pain
[ ] Yes [ ] No Change in bowel habits
[ ] Yes [ ] No Ulcers or Gastritis
[ ] Yes [ ] No Colon Cancer

Genitourinary

[ ] Yes [ ] No Urinary Tract Infection
[ ] Yes [ ] No Painful Urination
[ ] Yes [ ] No Blood in your Urine
[ ] Yes [ ] No Difficulty starting or stopping the stream
[ ] Yes [ ] No Incontinence
[ ] Yes [ ] No Kidney Stone
[ ] Yes [ ] No Prostate Cancer (male)
[ ] Yes [ ] No Endometriosis (female)
[ ] Yes [ ] No Cancer: [ ] Uterine [ ] Cervical

Musculoskeletal

[ ] Yes [ ] No Broken Bones – List: _____
[ ] Yes [ ] No Arm or Leg Weakness
[ ] Yes [ ] No Back Pain
[ ] Yes [ ] No Arm or Leg Pain
[ ] Yes [ ] No Joint Pain or Swelling
[ ] Yes [ ] No Arthritis

Integumentary

[ ] Yes [ ] No Skin Disease
[ ] Yes [ ] No Skin Cancer
For Females Only:
[ ] Yes [ ] No Breast: [ ] Pain [ ] Tenderness [ ] Swelling
[ ] Yes [ ] No Nipple Discharge
[ ] Yes [ ] No Date of last mammogram: _____ Results: _____

Neurological

[ ] Yes [ ] No Fainting Spells or "Blacking Out"
[ ] Yes [ ] No Seizures
[ ] Yes [ ] No Problems with memory
[ ] Yes [ ] No Disorientation
[ ] Yes [ ] No Difficulty with Speech
[ ] Yes [ ] No Inability to concentrate
[ ] Yes [ ] No Double or Blurred Vision
[ ] Yes [ ] No Face Weakness
[ ] Yes [ ] No Coordination in Arm and Legs

Psychiatric

[ ] Yes [ ] No Anxiety
[ ] Yes [ ] No Depression
[ ] Yes [ ] No Other Psychiatric Disorder / Treatment

Endocrine

[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Thyroid Disease
[ ] Yes [ ] No Increased Appetite
[ ] Yes [ ] No Excessive Thirst or Urination
[ ] Yes [ ] No Hormone Problems

Hematologic / Lymphatic

[ ] Yes [ ] No Anemia
[ ] Yes [ ] No Hemophilia
[ ] Yes [ ] No Bleeding Tendencies
[ ] Yes [ ] No Persistent Swollen Glands or Lymph Nodes
[ ] Yes [ ] No Blood Transfusion: If yes – Date(s)_____

Allergic / Immunologic

[ ] Yes [ ] No Food Allergies
[ ] Yes [ ] No Inhalant (Nasal) Allergies
[ ] Yes [ ] No Immunologic Disorders

Past History:

Please list any prior major illness:

Date Illness

_____

_____

_____

_____

_____

_____

List any prior major injuries and describe briefly:

Date Injury Description

_____

_____

_____

_____

_____

_____

Surgery and / or Hospitalization:

Date Surgery / Hospitalization Outcome

_____

_____

_____

_____

_____

_____

Have you ever had problems with anesthesia? □ Yes □ No

Current Medications:

Name of Medication	Dose/Frequency	Prescribing Physician

Allergies:
(Medications, Food, Enviroment, Etc.)

_____

_____

_____

Family History:

Family Member	Age	A= Alive D= Deceased	Health Status / Cause of Death
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			
Mother:			
Father:			
[ ] Sister [ ] Brother:			
[ ] Sister [ ] Brother:			
[ ] Sister [ ] Brother:			
[ ] Sister [ ] Brother:			

Social History:

Occupation: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Do you have any children? [ ] No [ ] Yes – How many? _____

Do you live alone? [ ] Yes
[ ] No – who lives with you? _____

Do you smoke? [ ] Yes - _____ packs of cigarettes per day for _____ years.

[ ] Yes – I smoke a [ ] Pipe [ ] Cigar

[ ] No – I have never

[ ] No – I quit smoking _____ years ago.
At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? [ ] No – Never

[ ] No – But I used to drink _____ a week.

[ ] Yes – [ ] Daily – amount? _____

[ ] One or more times a week. Amount? _____

[ ] One of more times a month. Amount? _____

Are you at risk for AIDS (e.g. Sexual orientation, Drug abuse, Previous blood transfusion, etc.) ?

[ ] No

[ ] Yes – Please explain: _____

The above information is accurate to the best of my knowledge.

_____ _____
Patient's Signature Date

I have reviewed the above information with the patient.

_____ _____
Physician's Signature Date