STANLEY C GRAVES M.D.
2022

PATIENT NAME: _____ DATE OF BIRTH ___/___/___

SOCIAL SECURITY NUMBER: _____

PHONE NUMBER: _____ ALTERNATE: _____

PHYSICAL ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT): _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

INSURANCE

PRIMARY INSURANCE: _____ SECONDARY INSURANCE _____

(PLEASE PROVIDE COPIES OF BOTH CARDS FOR UPDATED INFORMATION)

INDUSTRIAL CASE: YES NO

ATTORNEY: _____ ATTORNEY PHONE NUMBER: _____

**********INSURANCE CONTRACT**********

I UNDERSTAND I AM FULLY RESPONSIBLE FOR ANY CHARGES FROM AN OFFICE VISIT, INJECTION, OR SUPPLIES RECEIVED BY DR. STANLEY GRAVES THAT ARE NOT COVERED BY MY INSURANCE.

_____ RESPONSIBLE PARTY _____ DATE

I UNDERSTAND THAT IF MY ACCOUNT IS SENT TO ANY OUTSIDE COLLECTION AGENCY I WILL BE RESPONSIBLE FOR THE COLLECTION FEES (40%) AS WELL AS ANY ACCRUED INTEREST ON MY OUTSTANDING BALANCE.

_____ RESPONSIBLE PARTY _____ DATE

I UNDERSTAND AND ACKNOWLEDGE THE OFFICE NO SHOW POLICY. IF I MISS AN APPOINTMENT OR FAIL TO CANCEL AN APPOINTMENT 24 HOURS PRIOR TO THE SCHEDULED TIME I WILL BE HELD RESPONSIBLE FOR A NO SHOW FEE OF $30.00

_____ RESPONSIBLE PARTY _____ DATE

PATIENT HISTORY FORM

Stanley Graves, MD

Patient Name:_____ **Date:**_____

Date of Birth:_____ **Age:**_____ **Weight:**_____ **Height:**_____

Current Employer:_____ **Position:**_____

Work Status: Full Time/ Part Time/ Restricted/ Disabled/ Retired/ Other:_____

Left/ Right **Hand Dominant?**

Condition/Problem: Right / Left/ Bilateral_____

_____

Date of Onset/ Injury:_____

How did the injury occur?_____

Sports Injury/ Work Injury/ Auto Accident/ Other

Current Symptoms:_____

_____

Describe how the injury occurred:_____

_____

_____

_____

_____

Circle any that pain problems that apply:

Aching
Periodic
Goes Elsewhere
Shooting
Burning
Electrical
Spasmodic
Dull
Sharp
Throbbing
Knife –Like
Tingling

Dislocation
Numbness
Swelling
Popping
Paralysis
Weakness
Giving Away
Soreness
Nausea
Grinding
Stiffness
Vomiting
Limited Motion
Fever/Chills
Tenderness

At Night
After Activity
During Activity
When Resting

Other:_____

_____

_____

_____

Previous Surgery:_____ **Year:** _____

_____ _____

_____ _____

_____ _____

Hospitalizations:_____ _____

_____ _____

_____ _____

Previous MRI/MRA:_____ **X-Ray:**_____ **CT:**_____

Circle all of the following diseases or medical problems that you have had:

High/ Low Blood Pressure
Anemia/ Transfusions
Radiation Treatments
Blood Clots/ Pulmonary Embolus
Hepatitis
HIV / AIDS
Hemophilia/ Abnormal Bleeding
Rheumatoid Arthritis
Artificial Bone or Joints
Bone Infections

Shortness of Breath
Epilepsy/ Seizures/ Fainting spells
Heart Attack/ Heart Bypass Surgery
Pacemaker
Heart Murmur/ Congenital Defect
Mitral Valve Prolapse
Bladder Problems / Kidney Problems
Bowel Problems
Diabetes
Polio

Eyes
Low back pain
Ears/ Nose
Stomach
Drug Abuse
Alcohol Abuse
Asthma
Breathing
Psychiatric
Gout

Medications:_____ **Dose** _____

_____ _____

_____ _____

_____ _____

_____ _____

Please List Any Allergies:_____ **Reaction:**_____

_____ _____

_____ _____

_____ _____

Personal Information:

Marital Status: Married/Single/Divorced/Separated/ Widow/ Other:_____

Children: Yes/ No **How Many:**_____

Do you live alone? Yes/ No

Do you exercise? Daily/ Weekly/ Rarely/ Never
Are you on a special diet? Yes/ No Explain: _____
History of substance abuse? Yes/ No Explain: _____
Do you currently smoke? Yes/No Explain: _____
Have you previously smoked? Yes/ No Explain: _____
Do you drink alcohol? Daily/ 1-2x's Per Week/ Never/ How much? _____

Patient Signature: _____

Consent to Treat a Minor

I Hereby Give My Consent for Treatment to: _____

Parent Signature _____ **Date:** _____

HIPAA Compliance Patient Consent Form

2022

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

Under the HIPAA (Health Insurance Portability and Accountability Act of 1996) Law, you have the right to restrict how your protected health information is used and disclosed.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment or healthcare operations.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we discuss your medical treatment with any members of your family? YES NO

May we release your medical records to any members of your family? YES NO

May we speak with them regarding scheduling, confirming or changing appointments? YES NO

May we leave a message on their answering machine? YES NO

If YES, please name the members allowed:

_____

_____

_____

By signing this form, you consent to the use and disclosure of your protected health information to the following members:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____

Date: _____

PHARMACY INFORMATION
Stanley Graves, MD

PATIENT NAME: _____

DATE OF BIRTH: _____

PHARMACY NAME: _____

PHONE NUMBER: _____

CROSS STREETS: _____

DATE _____