Patient Information

Please Print Clearly & Complete All Information

Name (First, Middle Initial, Last)

____

Address:______________________________**P.O. Box:**__________

City:______________________**State:**_______**Zip Code:**________

Date of Birth:_______________**Age:**_____**Sex:Male/Female**______

Marital Status:S-M-W-D Social Security#:_____________________

Home Phone # __________________**Work Phone #**_____________

e-mail address ____

Employer____

Employer Phone _______________________________________

Circle One: Employed Full-time/ Employed Part-time/ Retired
Full-time Student/ Part-time Student

Emergency Contact

Name:____

Address:____

Phone# ________________________**Relationship**____________

Notice of Privacy Practices:

I hereby assign, transfer, and set over to Dr. Anne L. Grady, D.O., P.A. all my rights, title, and interest to my Protected Health Information (PHI) to obtain treatment, payment, and healthcare or for operational purposes such as quality assurance. I authorize the release of any medical information to determine these benefits.

I understand that I am financially responsible for all charges whether or not they are covered by my insurance, and will notify Dr. Anne Grady, D.O.,P.A. of any change in my health insurance. Also, I have the right and obligation to correct any information which may materially differ from those set forth here initially.

I understand that Dr. Grady is legally bound to limit my PHI and a 'Consent for Release of Medical Information' form is a requirement for the disclosure of my PHI to other parties. I also understand that there are legitimate uses and disclosures which consent, or authorization, or opportunity to agree or object is not required. Such non-routine requests will be approved by Dr. Grady solely.

I promise to promptly notify Dr. Anne L. Grady, D.O., P.A. if there is any material change in my health or those of my dependents. Furthermore, I understand that I will have reasonable access to my medical records under the terms and conditions set forth by Dr. Grady, D.O., P.A. I also give permission for myself and/or my dependents (minor under the age of 18) to be treated for any medical problems while under the care of Dr. Grady and/or any designates. This authorization shall remain valid until written notice is given by me or my representative revoking said authorization.

Office Use Only

Date of Office Visit/Initial

Date	Patient Initial

Signature **Date** **Witness Initial**

Name_____ Date of Birth___/____/_____ Date ____/____/_____

Problems/ Chief Complaints to discuss on initial office visit:
1._____

2._____
Medication Refills requested on initial office visit:
1._____ 2._____

3._____ 4._____
Hospitalizations or Surgeries

Hospitalization/ Surgery	**Date**	**Reason**	**Surgeon**	**Hospital**

Medications (list all medications, dose and frequency per day)

1.	6.
2.	7.
3.	8.
4.	9
5.	10.

Drug Allergies

Medication, Food, Environmental	Reason	Date

Vaccinations-
Do you have a list of your vaccinations?_____ Are you up to date with vaccinations? _____

Have you had any adverse reactions to any vaccination?_____

Name_____ Date of Birth___/____/_____ Date ____/____/_____

Your Medical/Family History (check box)

	Yourself	Father	Mother	Siblings B-brother S-Sister	Father's Parents Grandfather	Father's Parents Grandmother	Mother's Parents Grandfather	Mother's Parents Grandmother
Age (or age at time of Death)								
Alive	X							
Cause of death								
Alcoholism								
Asthma								
Bleeding Disorder								
Cancer (specify)								
Diabetes (type)								
Epilepsy /Convulsion								
Glaucoma								
Heart Disease								
High Blood Pressure / Hypertension								
Kidney Disease								
Mental Illness (specify)								
Migraine								
Osteoporosis								
Thyroid Disease								
Other _____								
Other _____								

Name_____ Date of Birth___/____/_____ Date ____/____/_____

Social History

Employment type - Employed / Unemployed/ Student/ Retired Profession-_____

Marital Status Single/ Married/ Divorced/ Widowed

Number of children

Sexual History not sexually active/ sexually active homosexual/ heterosexual/ bisexual multiple partners high risk behavior

Exercise none rarely daily weekly type of activity_____

Smoking- never smoked current smoker former smoker (year_____) <1ppd 1-2ppd 2-3ppd > Secondhand smoker

Tobacco use cessation counseling- are you interested in stopping? Yes no

Illicit drug use yes no

Alcohol Use none rare 1-2 drinks / week 3-6 drinks/ week Daily Occasionally

Caffeine intake none rarely daily many times per day coffee/ tea soda other caffeine_____