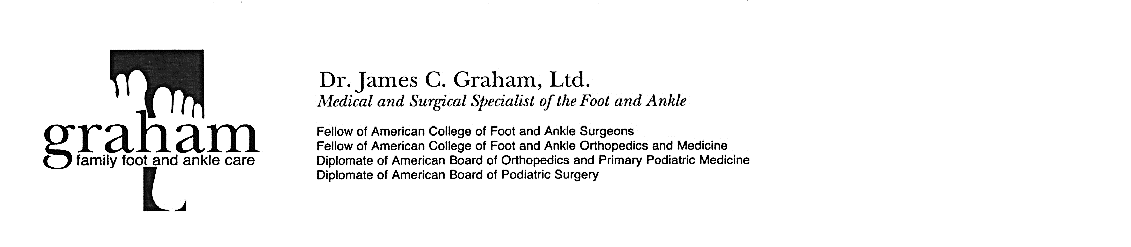
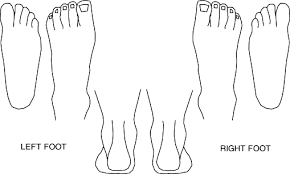
|  |
| --- |
| **DEMOGRAPHICS** Date |
| Last Name First Name M.I. Date of Birth |
| Social Security Number |
| Address City State Zip |
| Home Phone Work Phone Cell Phone |
| Biological Sex  Male Employer Email  Female |
| Primary Care Provider Date of Last Visit |
| Marital Status  Single  Married  Divorced  Widowed  Separated |
| Employment Status  Full Time  Part Time  Not Employed  Self Employed Retired Military Duty |
| Student  Full Time  Part Time  Not a Student |
| Emergency Contact Emergency Contact Phone |
| Race  White/Caucasian  Asian  Native Hawaiian  Other Pacific Islander  Black/African American  American Indian/Alaska Native  More than one race  Decline to Answer |
| Language  English  Spanish  Other  Ethnicity  Hispanic/Latino  Non-Hispanic/Latino  Decline to Answer |
| Guarantor’s Name: Relation to Patient: DOB: SS# Address: |
| **PRIMARY INSURANCE POLICY INFORMATION** |
| Policy Holder Name Policy Holder Mailing Address  Same as Patient  Other: |
| Policy Holder Primary Phone Policy Holder Relationship  Self  Spouse  Child  Other: |
| Policy Holder Date of Birth Policy Holder E-mail |
| Insurance Company Name |
| Insurance Identification Number Insurance Group Number |
| **SECONDARY INSURANCE POLICY INFORMATION** |
| Policy Holder Name Policy Holder Mailing Address  Same as Patient  Other: |
| Policy Holder Primary Phone Policy Holder Relationship  Self  Spouse  Child  Other: |
| Policy Holder Date of Birth Policy Holder E-mail |
| Insurance Company Name |
| Insurance Identification Number Insurance Group Number |



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **HEALTHCARE** Patient Name: DOB:  Please list all your other healthcare providers (specialist, chiropractors, dentists, optometrists, etc.) | | | | | | |
| Provider | | Specialty | | | Date of Last Visit (mm/yyyy) | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
| PRIMARY PHARMACY City: | | | | | | |
| **MEDICAL HISTORY**  Have you ever had any of the following conditions? (check all that apply) | | | | | | |
|  | CONDITION | COMMENTS |  | CONDITION | | COMMENTS |
|  | Alcohol/Drug Abuse |  |  | Gynecological Conditions (Endometriosis) | |  |
|  | Allergy/Hay Fever |  |  | Gynecological Conditions (Fibroids) | |  |
|  | Anemia |  |  | Heartburn/Reflux (GERD) | |  |
|  | Anxiety |  |  | Hepatitis – Type A/Type B/Type C | |  |
|  | Arthritis (Rheumatoid) |  |  | High Blood Pressure | |  |
|  | Arthritis (Osteoarthritis) |  |  | High Cholesterol | |  |
|  | Asthma |  |  | Inflammatory Bowel Disease | |  |
|  | Atrial Fibrillation |  |  | Irritable Bowel Syndrome | |  |
|  | Bipolar Disorder |  |  | Kidney Disease/Failure | |  |
|  | Bladder Problems |  |  | Kidney Stones | |  |
|  | Blood Clot (leg/lung) |  |  | Liver Disease | |  |
|  | Blood Transfusion |  |  | Low Thyroid/Hypothyroidism | |  |
|  | Breast Condition (Benign) |  |  | Lupus | |  |
|  | Cancer Breast |  |  | Migraine/Tension Headaches | |  |
|  | Cancer Colon |  |  | Overactive Thyroid/Hyperthyroidism | |  |
|  | Cancer Lung |  |  | Osteoporosis | |  |
|  | Cancer Prostate |  |  | Pancreatitis | |  |
|  | Cancer (other type) |  |  | Pneumonia | |  |
|  | Cataracts |  |  | Pregnancy | |  |
|  | Colon Polyp |  |  | Prostate Enlargement/Nodules | |  |
|  | Coronary Artery Disease/Hearth Attack |  |  | Seizures/Epilepsy | |  |
|  | Depression |  |  | Skin Cancer | |  |
|  | Diabetes (Type1) |  |  | Skin Condition (Eczema/Psoriasis) | |  |
|  | Diabetes (Type 2) |  |  | Sleep Apnea | |  |
|  | Diverticulosis |  |  | Stomach Ulcer | |  |
|  | Emphysema (COPD) |  |  | Stroke | |  |
|  | Fractures (broken bones) |  |  | UTI | |  |
|  | Gallbladder Disease |  |  | Other (list) | |  |
|  | Glaucoma |  |  | Other (list) | |  |
|  | Gout |  |  | Other (list) | |  |
| Hearing:  Hearing aid, right ear  Hearing aid, left ear  Hearing aids, both ears  Deaf, right ear  Deaf, left ear  Deaf, both ears Other | | | | | | |
| Vision (check all that apply):  Prescription glasses  Over-the-counter glasses  Contact lenses  Legally blind, right eye  Legally blind, left eye  Legally blind, both eyes | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **SURGICAL AND HOSPITALIZATION HISTORY**  List all past surgeries and hospitalizations | | | |
| Reason for Visit | Year | Facility | Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **FOOT PAIN** | | | |
| Does foot pain limit your desired activities?  Yes  No  Do you have any difficulty in walking?  Yes  No  Any pain in calves or buttocks when walking?  Yes  No  Is the pain relieved by stopping and standing still?  Yes  No  Did you previously or do you now wear: Shoe inserts  Yes  No Orthotics  Yes  No Did they help?  Yes  No  List the sports/dance you are active in:  Are your first steps out of bed painful?  Yes  No Then subsides?  Yes  No  Do you get leg cramps during the day?  Yes  No At night?  Yes  No  Percent of waking hours spent on your feet? (circle one) 20% 40% 60% 80% 100%  My first problem is  Left  Right  Both  It causes me difficulty  Walking  Wearing Shoes  And/Or:  Is the problem work related?  Yes  No  How long ago did the problem start?  Is your pain/discomfort?  None  Light Moderate  Strong  Severe  Shooting  Throbbing  Sharp  Burning  Dull  Itching  Aching  Tenderness  Tingling  Numbness  Previous treatments/remedies?  Please mark the location of your first problem or pain on the diagrams below with a 1.  Describe your problem below and its cause if you know. Please describe associated pain. | | | |



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY HISTORY** Patient Name: D.O.B. | | | | | | | | | | | | | |
|  | DISEASE | FATHER | MOTHER | CHILD | SIBLING | GRANDPARENTS | | OTHER | COMMENTS | | | | |
|  | No significant history known |  |  |  |  |  | |  |  | | | | |
|  | Alcoholism/Drug Abuse |  |  |  |  |  | |  |  | | | | |
|  | Asthma |  |  |  |  |  | |  |  | | | | |
|  | Autoimmune Disease |  |  |  |  |  | |  |  | | | | |
|  | Bleeding or Clotting Disorder |  |  |  |  |  | |  |  | | | | |
|  | Cancer: |  |  |  |  |  | |  |  | | | | |
|  | Breast Cancer |  |  |  |  |  | |  |  | | | | |
|  | Colon/Rectal Cancer |  |  |  |  |  | |  |  | | | | |
|  | Lung/Bronchus Cancer |  |  |  |  |  | |  |  | | | | |
|  | Non-Hodgkin Lymphoma Cancer |  |  |  |  |  | |  |  | | | | |
|  | Prostate Cancer |  |  |  |  |  | |  |  | | | | |
|  | Colon Poly |  |  |  |  |  | |  |  | | | | |
|  | Coronary Artery Disease (Heart Attack. Angina) |  |  |  |  |  | |  | Age of Onset: | | | | |
|  | Depression/Suicide/Anxiety |  |  |  |  |  | |  |  | | | | |
|  | Diabetes – Type 1 (Childhood Onset) |  |  |  |  |  | |  |  | | | | |
|  | Diabetes – Type 2 (Adult Onset) |  |  |  |  |  | |  |  | | | | |
|  | Emphysema (COPD) |  |  |  |  |  | |  |  | | | | |
|  | Genetic Disorder (Explain) |  |  |  |  |  | |  |  | | | | |
|  | Heart Disease |  |  |  |  |  | |  |  | | | | |
|  | Hepatitis (A, B or C) |  |  |  |  |  | |  |  | | | | |
|  | High Blood Pressure (Hypertension) |  |  |  |  |  | |  |  | | | | |
|  | High Cholesterol |  |  |  |  |  | |  |  | | | | |
|  | Hypothyroidism/Thyroid Disease |  |  |  |  |  | |  |  | | | | |
|  | Kidney Disease |  |  |  |  |  | |  |  | | | | |
|  | Migraine Headaches |  |  |  |  |  | |  |  | | | | |
|  | Osteoporosis |  |  |  |  |  | |  |  | | | | |
|  | Stroke |  |  |  |  |  | |  |  | | | | |
|  | Other (Please list) |  |  |  |  |  | |  |  | | | | |
|  |  |  |  |  |  |  | |  |  | | | | |
|  |  |  |  |  |  |  | |  |  | | | | |
| **SOCIAL HISTORY** | | | | | | | | | | | | | |
| Occupation Student  Yes  No Retired  Yes  No Year | | | | | | | | | | | | | |
| Highest education level completed  Less than high school  High school/GED  Trade school  Some college  College graduate  Graduate school  Post graduate | | | | | | | | | | | | | |
| Housing  Apartment  Condominium  House  Townhome  Assisted living  Correctional institution Homeless shelter  Nursing home  Mobile home | | | | | | | | | | | | | |
| Living Arrangement  Lives alone  Lives with spouse  Lives with family member(s)  Lives with roommate(s)  Lives with caregiver  Assisted living or nursing home facility | | | | | | | | | | | | | |
| Please check any of the following forms you have completed  Living will  Power of attorney for health care  Legal Guardianship  Practitioner order for life-sustaining treatment (POLST) (Formerly referred to as a DNR)  Have you experienced a fall or problems with walking or balance in this calendar year?  Yes  No  Unsure | | | | | | | | | | | | | |
| In the past year, how often have you used the following? | | | | | | | None | | | Rarely | Moderately | Daily | Quit |
| Monthly Alcohol: Men – 5 or more drinks a day  Women – 4 or more drinks a day | | | | | | |  | | |  |  |  |  |
| Prescription drugs for non-medical reasons | | | | | | |  | | |  |  |  |  |
| Recreational or street drugs | | | | | | |  | | |  |  |  |  |
| Tobacco Use  Never a tobacco user  Current tobacco user  Former tobacco user | | | | | | | | | | | | | |
|  | | | | | | | | | | Yes | Packs - #/Day | Years | Years Quit |
| Cigarettes | | | | | | | | | |  |  |  |  |
| Chewing Tobacco | | | | | | | | | |  |  |  |  |
| Snuff | | | | | | | | | |  |  |  |  |
| Pipe Tobacco | | | | | | | | | |  |  |  |  |
| Cigars | | | | | | | | | |  |  |  |  |
| E-cigarettes Nicotine % | | | | | | | | | |  |  |  |  |
| Over the last 2 weeks, how often have you been bothered by any of the following problems?  Little interest or pleasure in doing things:  Not at all  Several days  More than half the days  Nearly every day  Feeling down, depressed, or hopeless:  Not at all  Several days  More than half the days  Nearly every day  Height Weight Shoe Size | | | | | | | | | | | | | |
| **ALLERGIES**  List all allergies or intolerance to medications. Indicate type of reaction.  NO KNOWN ALLERGIES | | | | | | | | | | | | | |
| ALLERGIES | | | | | | | TYPE OF REACTION | | | | | | |
|  | | | | | | |  | | | | | | |
|  | | | | | | |  | | | | | | |
|  | | | | | | |  | | | | | | |
|  | | | | | | |  | | | | | | |
|  | | | | | | |  | | | | | | |
| **MEDICINE**  List all prescriptions and non-prescription medications (over-the-counter), vitamins, home remedies, birth control pills, herbs, inhalers, etc.  I DO NOT TAKE MEDICATIONS | | | | | | | | | | | | | |
| MEDICINE | | | | | | | DOSE (mg/pills) | | | | TIMES PER DAY | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
|  | | | | | | |  | | | |  | | |
| **VACCINES**  Did you receive a flu vaccine between August of the previous year through March of the current year?  Yes  No  Unsure  Have you ever received a pneumonia vaccine?  Yes Year  No  When was your last tetanus vaccine? Year | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **REVIEW OF SYSTEMS** Patient Name: D.O.B.   1. Do you have or have ever had any of the following? | |
| CONSTITIUTIONAL | Fever  Chills  Fatigue  Loss of appetite  Weight gain/loss  Night sweats  Heat/cold intolerance  Weakness |
| EYES | Eye pain  Red eyes  Eye discharge  Itchy eyes  Blurred vision  Vision changes |
| ENT | Earache  Loss of hearing  Nasal congestion  Sneezing  Sore/scratchy throat  Hoarseness  Nose bleeds  White patches/sores in mouth  Change in voice  Facial pain/pressure |
| CARDIOVASCULAR | Chest pain/tightness  Palpitations  Racing heart  Lightheadedness  Lower leg swelling  Shortness of breath at night  Pain in legs while walking |
| RESPIRATORY | Shortness of breath  Wheezing  Cough  Difficulty sleeping flat  Coughing/vomiting blood |
| GASTROINTESTINAL | Abdominal pain  Abdominal bloating  Abdominal cramps  Excessive gas  Nausea  Vomiting  Diarrhea  Unable to pass gas  Constipation  Rectal Bleeding  Black stools  Heartburn  Difficulty swallowing  Change in bowel habits |
| GENITOURINARY | Painful urination  Urinary frequency  Urinary urgency  Pelvic pain  Dark urine  Blood in urine  Urinary incontinence  Urinary hesitancy  Testicular pain  Change in bowel habits |
| MUSCULOSKELETAL | Joint pain  Muscle Aches  Muscle stiffness  Back pain  Joint swelling  Joint stiffness  Muscle spasms  Limping  Redness/warmth over joints |
| INTEGUMENTARY/SKIN | Change in a mole  Change in color of skin  Change in skin texture  Photosensitivity  Cracking of skin  Itching  Open wounds |
| NAILS | Difficulty to trim  Break easily  Fingernail deformity  Fingernail discoloration  Fingernail thickening  Toenail deformity  Toenail discoloration Toenail thickening |
| NEUROLOGICAL | Headache  Confusion  Dizziness  Fainting (Syncope)  Tingling sensation  Leg numbness  Leg weakness  Difficulty walking  Seizures  Memory loss |
| PSYCHIATRIC | Trouble sleeping  Irritable  Anxiety  Depression |
| ENDOCRINE | Hot flashes  Night sweats  Muscle weakness |
| HEMATOLOGIC AND LYMPHATIC | Swollen glands  Easy bleeding  Easy bruising  Yellowing of skin (jaundice) |

**Billing Policies for Dr. James Graham**

We will bill your insurance as a courtesy at the time of your initial visit, a new patient is required to pay in full the charge for the office visit and additional charges (x-rays, procedures, etc.) unless the patient has insurance with A COPAY or a percentage of the total charges required. Financial agreements may be set up with the office manager should this not be possible. Statements will be mailed on a monthly basis, with all balances reflecting payments made throughout the month.

This office will bill each patient’s primary insurance carrier. Patients should be aware of their insurance coverage and be able to estimate the amount of charges that the insurance company will determine to be the patient’s share. The amount should be paid upon the receipt of each statement. Despite this, the patient is responsible for the entire balance due regardless of whether the insurance company is billed or pays any portion of the balance. Payment in full is expected in three months. An interest charge of 1.5% will be added after charges are outstanding for longer than 60 days.

Insurance policies are CONTRACTUAL AGREEMENTS between PATIENTS AND INSURANCE COMPANIES. We are, therefore, not able to answer questions regarding specific coverage, but will offer assistance in understanding of any activity by the insurance company reflected in the patient’s account. It is not our policy or our responsibility to contact insurance companies to determine coverage in advance or to establish the reasoning behind insurance payments which are less than expected. Patients should keep in touch with their insurance companies to determine the status of any unpaid clams which have been billed by our office. Also, it is the patient’s responsibility to question this office participation in any HMO’s or PPO’s. We are not responsible for any restrictions or requirements set forth by any HMO’s or PPO’s if we are not under contractual agreement with the company.

If you are claiming a Worker Comp case against your employer, you must have the name of the Insurance Company, claim number, and a contact person. If you do not have this information, YOU will be responsible for the account.

This office DOES NOT accept Medicaid patients. Patients will be responsible for the balance in full at the time of the visit.

RESPONSIBLE PARTY: We understand court decisions sometimes mandate responsible party following a divorce. In situations such as this, we ask that the representing parent/party pay for the co-payments/deductible at the time of the service. We will provide a receipt for reimbursement purposes.

There may be a FEE for the completion of disability forms, mortgage forms, auto insurance forms and bank forms of all types. Similarly, a fee will be assessed for the provision of copies of medical records in certain circumstances. These fees must be paid before the forms are completed. We regret this additional charge, but the number of forms completed has become overwhelming and requires considerable staff time.

This office ODES NOT participate in fraudulent practice of writing off the amount considered to the patient’s portion after payment has been received from the insurance company.

In the event your account becomes past due, it may be turned over to a collection agency and/or attorney for collection. If your account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney fees of 33% of the balance due.

By singing below, (1) you promise to pay the account; (2) state that you are the patient or legal guardian or parent of the patient; (3) you authorize and direct all insurance companies to send payment directly to James C Graham, DPM; (4) are if any insurance company pays you directly for services you will pay the money immediately to Dr. Graham; (5) if you fail to promptly pay the balance in full, provider may employ an attorney or collection agency to collect the balance due and legal fees and expenses will be added to the account balance owed. If you have any questions regarding our office policies or wish to make special billing arrangements, please feel free to contact our office manager.

“I have read this entire form and the terms contained in it and believe I understand it. I am signing it of my own free will and authorize the Provider to release medical information from my file for any reasonable purpose involving the processing of claims/payments.”

**Signature of Responsible Party for this Account Date**



