|  |
| --- |
| **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 [ ]  NoDo you have any difficulty in walking? [ ]  Yes [ ]  NoAny pain in calves or buttocks when walking? [ ]  Yes [ ]  NoIs the pain relieved by stopping and standing still? [ ]  Yes [ ]  NoDid you previously or do you now wear: Shoe inserts [ ]  Yes [ ]  No Orthotics [ ]  Yes [ ]  No Did they help? [ ]  Yes [ ]  NoList the sports/dance you are active in: Are your first steps out of bed painful? [ ]  Yes [ ]  No Then subsides? [ ]  Yes [ ]  NoDo you get leg cramps during the day? [ ]  Yes [ ]  No At night? [ ]  Yes [ ]  NoPercent of waking hours spent on your feet? (circle one) 20% 40% 60% 80% 100%My first problem is [ ]  Left [ ]  Right [ ]  BothIt causes me difficulty [ ]  Walking [ ]  Wearing ShoesAnd/Or: Is the problem work related? [ ]  Yes [ ]  NoHow long ago did the problem start?Is your pain/discomfort? [ ]  None [ ]  Light [ ] Moderate [ ]  Strong [ ]  Severe [ ]  Shooting [ ]  Throbbing [ ]  Sharp [ ]  Burning [ ]  Dull [ ]  Itching [ ]  Aching [ ]  Tenderness[ ]  Tingling [ ]  NumbnessPrevious 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 dayFeeling down, depressed, or hopeless: [ ]  Not at all [ ]  Several days [ ]  More than half the days [ ]  Nearly every dayHeight 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 [ ]  UnsureHave you ever received a pneumonia vaccine? [ ]  Yes Year  [ ]  NoWhen 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**



