**DATE:** ______________________________

LAST NAME: ______________________________

FIRST NAME/
MIDDLE INITIAL: ______________________________

ADDRESS: ______________________________

______________________________

CITY: ____________ STATE: _____ ZIP: ____________

HOME PHONE: ______________________________

OTHER PHONE: ______________________________

SEX: Male Female

DATE OF BIRTH: ________________ AGE: _________

EMAIL: ______________________________

MARITAL STATUS: Single Married Widowed Divorced Separated

SOCIAL SECURITY#:______________________________

EMPLOYER: ______________________________

ADDRESS: ______________________________

CITY__________________STATE:______ ZIP: ______________

PHONE: ____________________________ EXT: ___________

OCCUPATION: ______________________________

NAME OF SPOUSE/PARENT/ GUARDIAN / RELATIVE:

NAME: ______________________________

ADDRESS: ______________________________

CITY: ____________________STATE:_____ ZIP: ___________

PHONE: ______________________________

SPOUSE DATE OF BIRTH (for insurance purposes): ________________

REFERRED BY: ______________________________

**HOW DID YOU HEAR ABOUT US?** ______________________________

## MEDICAL HISTORY

***WHAT ARE YOU BEING SEEN FOR TODAY? PLEASE CIRCLE ALL THAT APPLY***

**RIGHT:** Shoulder Elbow Wrist Hand Finger (thumb index middle ring, small) Hip Knee Leg Ankle Foot Toe (1st 2nd 3rd 4th 5th)

**LEFT**: Shoulder Elbow Wrist Hand Finger (thumb index middle ring, small) Hip Knee Leg Ankle Foot Toe (1st 2nd 3rd 4th 5th)

BACK (upper middle lower) NECK RIBS OTHER: ______________________________

DATE OF INJURY: ____________________ ***OR*** HOW LONG HAVE YOU HAD THIS PROBLEM? ____________ days weeks months years

DESCRIBE ***IN DETAIL*** HOW THIS OCCURRED? ______________________________

______________________________

***IF INJURED, WHERE DID YOU INJURE YOURSELF?*** **Home School Work Auto Sports Other:**______________________________

WERE YOU SEEN AT AN EMERGENCY ROOM? Yes No

WHEN? ______________________________

WHERE? ______________________________

WERE XRAYS TAKEN? Yes No

PLEASE LIST THE ***PHYSICIANS*** YOU ARE TREATING WITH:

1. FAMILY DOCTOR / PRIMARY CARE PHYSICIAN ______________________________
2. SPECIALIST(s)______________________________
3. OTHER ______________________________

PLEASE LIST ANY ***ALLERGIES*** YOU HAVE: ______________________________

______________________________

PLEASE LIST ANY/ALL MEDICATIONS OR DRUGS YOU ARE NOW TAKING, INCLUDING OVER-THE-COUNTER MEDICATIONS, HERBAL MEDICATIONS AND VITAMINS:
______________________________

______________________________

WHAT ARE YOU TAKING THESE MEDICATIONS FOR? ______________________________

PLEASE LIST YOUR PHARMACY ADDRESS AND TELEPHONE #: ______________________________

ARE YOU CLAUSTROPHOBIC? Yes No DO YOU REQUIRE MEDICATION FOR DIAGNOSTIC TESTING? Yes No

# PAST MEDICAL HISTORY

| ***HOSPITALIZATIONS*** | ***DESCRIPTION*** | ***YEAR*** | ***HOSPITAL*** |
|---|---|---|---|
| ILLNESS | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| SURGERIES | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| OTHER (REASON) | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |
| | ________________________ | ________ | ___________________________ |

ARE YOU NOW OR HAVE YOU BEEN UNDER A DOCTOR'S CARE FOR A SERIOUS ILLNESS OR CONDITION? Yes No

PLEASE LIST ILLNESS/CONDITION: ___________________________________________________________________________

_____________________________________________________________________________________________________

# SOCIAL/HEALTH RISK HISTORY

Yes No

___ ___ DO YOU SMOKE? HOW MAY CIGARETTES/PACKS PER DAY? __________________________________

___ ___ DO YOU USE ALCOHOL? IF YES, PLEASE CIRCLE: OCCASIONAL MODERATE HEAVY

___ ___ DO YOU USE SEATBELTS?

___ ___ DO YOU EXERCISE? WHAT TYPE OF ACTIVITY? ________________________________________________

___ ___ ARE YOU EXPOSED TO WORK HAZARDS AT YOUR PLACE OF EMPLOYMENT?

___ ___ DO YOU HAVE A DIET OR EATING DISORDER?

WHO DO YOU PRESENTLY LIVE WITH? SELF SPOUSE FAMILY OTHER: __________________________

# FAMILY HISTORY

*IF YOU ARE ADOPTED, PLEASE CHECK HERE AND SKIP TO THE NEXT SECTION:* ___________

HAS ANYONE IN YOUR IMMEDIATE FAMILY EVER HAD THE FOLLOWING? YES NO
IF YES, PLEASE CIRCLE FAMILY MEMBER

___Heart Attack/Heart Disease/Surgery Father Mother Sister(s) Brother(s)

___High Blood Pressure/Cholesterol Father Mother Sister(s) Brother(s)

___Breast/Ovarian/Uterine Cancer Mother Sister (s)

___Prostate Cancer Father Brother(s)

___Other Cancer Father Mother Sister(s) Brother(s)

___ Diabetes (Insulin Dependent) Father Mother Sister(s) Brother(s)

___ No longer living Father Mother Sister(s) Brother(s)

# REVIEW OF SYSTEMS

Genitourinary

Yes No
___ ___ Frequent bladder infections
___ ___ Bladder, urinary or kidney problems
___ ___ Abnormal Pap Smear
___ ___ Abnormality of uterus
___ ___ Pelvic infection/pain (PID)
___ ___ Recurrent vaginal infection
___ ___ Sexually transmitted disease
___ ___ Breast problems
___ ___ Prostate problems
___ ___ Colon Problems

Cardiovascular

Yes No
___ ___ Chest pain
___ ___ Heart disease/murmur
___ ___ High blood pressure
___ ___ High cholesterol/Triglycerides
___ ___ Thrombophlebitis/blood clots in veins or lungs
___ ___ Shortness of breath

Gastrointestinal

Yes No
___ ___ Stomach problems
___ ___ Liver disease/jaundice
___ ___ Hepatitis
___ ___ Gall bladder disease
___ ___ Ulcers
___ ___ Diarrhea
___ ___ Bowel/bladder problems

General

Yes No
___ ___ My health is generally good
___ ___ Recent weight gain/loss
___ ___ Frequent colds/flu
___ ___ Chronic fatigue (> 6 mos)
___ ___ Cancer ______________
___ ___ Genetic condition

Neurologic

Yes No
___ ___ Migraine headaches
___ ___ Sensory difficulties (numbness, hearing, taste, smell)
___ ___ Stroke
___ ___ Seizures/Epilepsy

Ears, Nose, Throat, Mouth

Yes No
___ ___ Hearing aid
___ ___ Hearing problems
___ ___ Dentures
___ ___ Teeth/Gum problems
___ ___ Frequent nosebleeds

Musculoskeletal

Yes No
___ ___ Broken bones/fractures
___ ___ Total joint replacements
___ ___ Joint pain/bone pain
___ ___ Arthritis/tendinitis

Eyes

Yes No
___ ___ Glasses
___ ___ Glaucoma
___ ___ Loss of vision
___ ___ Other eye problems

Psychology

Yes No
___ ___ Depression
___ ___ Anxiety
___ ___ Severe mood swings
___ ___ Under care of physician

Hematologic

Yes No
___ ___ Anemia
___ ___ Blood clotting disorder
___ ___ Blood transfusion
___ ___ Sickle Cell Anemia/Trait/Thallesimia

Endocrine

Yes No
___ ___ Diabetes/Diabetes of pregnancy
___ ___ Thyroid problems
___ ___ Asthma

Immunizations

Yes No
___ ___ Rubella (German measles)
___ ___ Chicken pox
___ ___ Tetanus

Skin

Yes No
___ ___ Acne
___ ___ Chronic rash/itching
___ ___ Eczema/Psoriasis

Respiratory

Yes No
___ ___ Chronic cough
___ ___ Other breathing problems

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# INSURANCE COVERAGE

PRIMARY INSURANCE COMPANY NAME: ______________________________ POLICY #: ____________________________________________________

*Subscriber's Name:* ____________________________ *DOB:* ________________ *Effective date:* ______________________

SECONDARY INSURANCE COMPANY NAME: ___________________________ POLICY #: ____________________________________________________

*Subscriber's Name:* ____________________________ *DOB:* ________________ *Effective date:* ______________________

OTHER INSURANCE COMPANY NAME: ________________________________ POLICY #: ____________________________________________________

*Subscriber's Name:* ____________________________ *DOB:* ________________ *Effective date:* ______________________

# WORKERS' COMPENSATION

EMPLOYER: ______________________________________________ INSURANCE: ________________________________________________________

ADDRESS: ______________________________________________ ADDRESS: __________________________________________________________

______________________________________________ __________________________________________________________

DATE OF INJURY: ___________________________________________ CLAIM #: ____________________________________________________________

INJURY REPORTED TO EMPLOYER? Yes No ARE YOU PRESENTLY WORKING? Yes No Full Duty Light/Modified Duty

# LIABILITY - (Auto / Slip & Fall)

TYPE OF ACCIDENT: _____________________________ WHERE? ___________________________________ WHEN? _______________________

INSURANCE COMPANY NAME/ADDRESS: ___________________________________________________________________________________________

# <u>CONSENT TO TREATMENT</u>

I hereby consent to the rendering of care by Franklin E. Mirrer, M.D., 215 Tollgate Road, Warwick, RI, 02886, which may include laboratory testing and other procedures, and such medical treatment as my Physician(s) or other Provider(s) consider to be necessary or advisable.

Patient will be responsible for bills to be paid at the time of service unless arrangements are made. A statement for professional services will be rendered.

***NOTE***: *It is to be understood that any payment received from a third party, such as insurance companies, will be credited to your account and you will be personally liable for any unpaid balances after a 30 day period. I understand that if I do not pay any amount which is owed to you within 30 days after receipt of your statement for services rendered, I will be in default of this agreement and I will pay any and all reasonable attorney fees, to the extend permitted by law.*

I hereby authorize **Franklin E. Mirrer, M.D**. ( the "Medical Practice") to release and/or transfer all records, opinions, reports, x-rays, laboratory tests and analyses, photostatic copies, abstracts of excerpts of any medical records or other information of any kind relating to the undersigned in the possession of the Medical Practice (hereinafter collectively referred to as "Confidential Health Care Information"), including those results related to tests for HIV, for the purpose of coordinating my health care, and/or coordinating the payment of claims with my health insurer. Provided, however, that this Consent for Release of Confidential Health Care Information shall not apply to Confidential Health Care Information maintained in connection with the performance of any federally assisted alcohol and drug abuse problem.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said doctor's additional protection.

DATE: ___________________________________ SIGNATURE: ________________________________________________________________
(Parent/Guardian must sign if patient is a minor)

DATE: ___________________________________ SIGNATURE: ________________________________________________________________
(Parent/Guardian must sign if patient is a minor)

DATE: ___________________________________ SIGNATURE: ________________________________________________________________
(Parent/Guardian must sign if patient is a minor)

## ***<u>NOTICE OF PRIVACY PRACTICES</u>***

We maintain protocols to ensure the security & confidentiality of your personal information. We have physical security in our building, passwords to protect our databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. At this office, we are committed to treating & using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how & when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective March 10, 2010 and applies to all protected health information as defined by federal regulations. Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: Basis for planning your care & treatment; Means of communication among the many health professionals who contribute to your care; Legal document describing the care you received; Means by which you or a third-party payer can verify that services billed were actually provided; Tool in educating health professionals; Source of date for medical research; Source of information for public health officials charged to improve the health of the state & nation; Source of date for our planning & marketing; Tool by which we can assess and continually work to improve the care we render & outcomes we achieve.

Although your health record is the physical property of this office, the information belongs to you. You have the right to: Obtain a paper copy of this notice of privacy policies upon request; Inspect & obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law); Amend your health record as provided by 45 CFR 164.526; Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528; Request confidential communications of your health information as provided by 45 CFR 164.522(b) and request a restriction on certain uses & disclosures of your information as provided by 45 CFR 164.522(a) – [however, we are not required by law to agree to a requested restriction].

Our practice is required to: Maintain the privacy of your health information; Provide you with this notice as to our legal duties & privacy practices with respect to information we collect & maintain about you; Abide by the terms of this notice; Notify you if we are unable to agree to a requested restriction; Accommodate reasonable requests you may have to communicate your health information We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not disclose your health information in a manner other than described in section regarding Examples of Disclosure for Treatment; Payment & Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b) (5), except to the extent that action has already been taken.

**Examples of Disclosure for Treatment, Payment & Health Operations**: *We will use your health information for treatment*. We may provided medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care**.** ***We will use your health information for payment***. We may disclose your information so that we can collect or make payment for health care services you receive. ***We may disclose your health information for our routine operations***. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. ***Consistent with applicable law, we may disclose medical information for the following***: to provide appointment reminders; to coroner, medical examiner or funeral directors; workers' compensation or other similar programs established by law; to public health or legal authorities charged with preventing or controlling disease, injury or disability; to researcher when their research has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal; to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation & transplant; as required by law for reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process or complying with the health oversight activities, such as audits, investigations & inspections necessary to ensure compliance with government regulations & civil rights laws; for military & veterans affairs or national security & intelligence activities; for services provided in our organization through contacts with business associates (i.e. – transcription services) due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do and to protect our health information we require the business associate to appropriately safeguard your information; to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement; for practice marketing to provide information about treatment alternatives or other health-related benefits & services that may be of interest to you; to your personal representative – or personal legally responsible for your care & authorized to act on your behalf in making decisions related to your health care; when we believe in good faith that your information is necessary to prevent a serious threat to your safety or that of another person – i.e.: – abuse, neglect, or domestic violence; to family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care – we may notify these individuals of your location/general condition; to an organization assisting in a disaster relief effort. ***For all non-routine operations***, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.