DR. CHRISTOPHER A. REEDER, D. O.

PATIENT INFORMATION

Have you or a family member been a patient here? ___ YES ___ NO If yes, name _____

Patients Name _____ MALE _____ FEMALE _____

Date of Birth _____ Age _____ Social Security Number _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Address _____ City, State, Zip _____

Phone: Home _____ Work _____ Cell _____

E-mail address _____ Employer _____

Emergency Contact _____ Telephone _____

BILLING/INSURANCE INFORMATION (must be completed to submit claims)

Responsible Party/Guarantor ___ Same as patient ___ Same as Policy Holder ___ Neither (complete section below)

Name: _____ DOB: _____

Address: _____ Phone #: _____

Relationship to Patient: _____

Employer: _____ Employer Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Effective Date: _____ Group #: _____

Policy #: _____ Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone #: _____

Employer: _____ Employer Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Effective Date: _____ Group #: _____

Policy #: _____ Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone #: _____

Employer: _____ Employer Address: _____

REFERRING PROVIDER

Name _____

Address _____

City, State, Zip _____

Phone #: _____

PRIMARY CARE PROVIDER

Name _____

Address _____

City, State, Zip _____

Phone #: _____

Was this an injury? ____ YES ____ NO Date of Injury? _____

_____ Work Related _____ Motor Vehicle Accident _____ Personal Injury

Are you working with an Attorney? _____ YES _____ NO If yes, Attorney Name _____

Referred by(list name): Doctor ____ Friend _____ Online _____ Attorney ____ Other ____

Name/Organization: _____

***Please complete the following pages**

CONSTITUTIONAL SYMPTOMS	NO	YES	***MUSCULOSKELETAL***	NO	YES
Good general health recently			Joint Pain		
Recent weight change			Joint stiffness and swelling		
Fever			Weakness of muscles or joints		
Fatigue			Back pain		
Headaches			Cold extremities		
EYES			Difficulty in walking		
Eye disease or injury			***INTEGUMENTARY*** (skin, breasts)		
Blurred or double vision			Rash or itching		
Wear glasses/contacts			Change in skin color		
Glaucoma			Change in hair or nails		
EARS/NOSE/MOUTH/THROAT			Varicose veins		
Hearing loss or ringing			Breast pain		
Earaches or draining			Breast lump		
Chronic sinus problem or rhinitis			Breast discharge		
Nose bleeds			History of skin cancer		
Mouth sores			Extensive sun exposure		
Bleeding gums			Tanning bed use		
Bad breath or bad taste			Changing spots		
Sore throat or voice change			***NEUROLOGICAL***		
Swollen glands in neck			Frequent or recurring headaches		
CARDIOVASCULAR			Lightheaded or dizzy		
Heart trouble			Convulsions or seizures		
Chest pain or angina pectoris			Numbness or tingling sensations		
Palpitations			Tremors		
Shortness of breath while walking/lying			Paralysis		
RESPIRATORY			Stroke		
Chronic or frequent cough			Head injury		
Spitting up blood			PSYCHIATRIC		
Shortness of breath			Memory loss or confusion		
Asthma or wheezing			Nervousness		
GASTROINTESTINAL			Depression		
Loss of appetite			Insomnia		
Change in bowel movements			***ENDOCRINE***		
Nausea or vomiting			Glandular or hormone problem		
Frequent diarrhea			Thyroid disease		
Painful bowel movement/constipation			Diabetes		
Rectal bleeding or blood in stool			Excessive thirst or urination		
Abdominal pain or heartburn			Heat or cold intolerance		
Peptic ulcer (stomach or duodenal)			Dry skin		
GENITOURINARY			Change in hat or glove size		
Frequent urination			***HEMATOLOGICAL/LYMPHATIC***		
Burning or painful urination			Slow to heal after cuts		
Blood in urine			Bleeding/bruising tendency		
Change in force/strain with urination			Anemia		
Incontinence or dribbling			Phlebitis		
Kidney stones			Past transfusion		
Sexual difficulty			Enlarged glands		
Male testicular pain					

Female patient only

Pain with periods: YES _____ NO _____

Irregular periods: YES _____ NO _____

Vaginal Discharge: YES _____ NO _____

Number of pregnancies _____ Number of miscarriages _____

Date of last pap smear _____

Date of last mammogram _____

HISTORY

Reason for visit: _____

Location of problem: _____

When did the problem start? _____

How severe is the problem? _____

How often do your experience the problem? _____

Does anything make this problem better or worse? If so, please list

_____

_____

Any other signs/symptoms? (drainage, swelling redness etc.)

_____

_____

MEDICAL HISTORY

Diabetes: YES _____ NO _____

Cancer: YES _____ NO _____

If yes, location _____

Arthritis/Gout: YES _____ NO _____

Bleeding tendency YES _____ NO _____

Venereal disease YES _____ NO _____

Hypertension: YES _____ NO _____

Stroke: YES _____ NO _____

Heart Trouble: YES _____ NO _____

Convulsions: YES _____ NO _____

Acute infections: YES _____ NO _____

Hereditary disease: YES _____ NO _____

Any known allergies to medicine? Please List

_____

Any other known allergies? List: _____

SOCIAL HISTORY

Marital status? _____

Use of alcohol (circle one): Never Rarely Moderate Daily

Use of drugs: (circle one): Never Rarely Moderate Daily

If yes, please list type _____

Excessive exposure at home or work the following: Fumes _____ Dust _____ Solvents _____ Airborne particles _____

FAMILY HISTORY	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

DR. CHRISTOPHER A. REEDER, D.O.

Consent for Treatment

I hereby authorize all medical treatments that may be considered advisable or necessary in the judgment of the provider.

Signature: _____ Date: _____

As a minor, I give authorization for evaluation and treatment without the presence of my parents or my guardian.

Signature: _____ Date: _____

Authorization for Release of Information

I hereby authorize Dr. Christopher A. Reeder, D.O., to release information requested by my insurance company or workers compensation carrier. I also authorize Dr. Christopher A. Reeder, D.O., to release information to any hospital or physician that I may be referred to by this office, as allowed by the HIPPA guidelines.

I hereby give my permission to Dr. Christopher A. Reeder, D.O., to disclose information regarding my treatment to:

Physician: _____ Phone: _____

Address: _____

In signing this release, I authorize my medical records to be faxed or mailed upon my request.

Signature: _____ Date: _____

Assignment of Benefits

I hereby authorize assignment and payment directly to Dr. Christopher A. Reeder, D.O., any medical benefits due for services. I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE. IF ACCOUNT BECOMES DELINQUENT AND IS TURNED OVER TO A LICENSED COMPANY FOR COLLECTION, I SHALL BE RESPONSIBLE TO PAY REASONABLE COLLECTION AND ATTORNEY FEES.

Signature: _____ Date: _____

Health Information Privacy Practices Acknowledgment

Do you authorize medical information to be shared with someone other than yourself? (if authorized person/organization is not a healthcare provider, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.) _____YES (if yes, please list) _____ NO

Name: _____ Relationship to Patient: _____

I wish to be contacted in the following manner (check all that apply):

Home Phone: Leave message ____ with detailed information ____ with call back information.

Work Phone: Leave message ____ with detailed information ____ with call back information.

Written Communication: ____ Mail to home address ____ Fax to: _____

Name (Print): _____ DOB: _____

Signature: _____ Date: _____