DAVID J. GRAY, M.D., P.C.
PATIENT REGISTRATION FORM

ACCT# ___________

BILLING/GUARANTOR INFORMATION

DATE: ________________________

First Name: ________________________ MI: ______ Last Name: ____________________________

Address: ____

City: ____________________________ State: _____________ Zip: ______________________

Telephone: ( ) __________________________

PATIENT INFORMATION

First Name: ________________________ MI: _____ Last Name: ____________________________

Address: ____

City: ____________________________ State: _____________ Zip: ______________________

Telephone: (____) _____________________ Emergency Phone: (_______) ______________________

Birth Date: ___________________________ Sex: __________ Martial Status: ____________________

Social Security No. ________________________ Referring Physician: ___________________________

Maiden/Previous Name: ____________________ Spouse's Name: ______________________________

Patient's Employer: ____

Employer's Address: ____ Suite #: ________

City: _______________________________________ State: _____________ Zip: _______________

Employer Phone: (_______) ____________________ Email: ____________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____

Group No: _________________ Policy No: ______________________ Copay Amt: __________

Subscriber Name: ____ Relationship to Patient: __________

Subscriber Sex: _________________ DOB: _____________ SSN: _____________________

Subscriber Employer: _______________________________________ Work Phone: _______________

Employer Address: ____

SECONDARY INSURANCE: ____

Group No: _______________ Policy No: _____________________________ Copay Amt: __________

Subscriber Name: ____________________________________ Relationship to Patient: _____________

Subscriber Sex: ______________ DOB: _______________ SSN: ____________________________

Subscriber Employer: _______________________________________ Work Phone: _______________

Employer Address: ____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with insurer).

I directly assign all medical/surgical benefits to David J. Gray, M.D., P.C. and understand that I am financially responsible for all charges not covered by insurances. I hereby authorize David J. Gray, M.D., P.C. to release all information necessary to secure the payment of benefits. In the event of non-payment, either by insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

In order to help control the cost of billing, we request payment be made for all office services at the conclusion of your visit unless other arrangements have been made prior to services being rendered.

_______________________________________ _______________________________________

Signature of Patient or Legal Representative Date

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, and information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_______________________________________ _______________________________________

Signature of Patient or Legal Representative Date

_________ I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information. I authorize David J. Gray, M.D., P.C. to fax my information to any party involved in my health care.

David J. Gray, M.D., P.C.
910 Adams Street, Suite 130
Huntsville, Alabama 35801
(256) 265-7957
Fax (256) 265-7965

Due to recent federal privacy guidelines (HIPPA), David J. Gray, M.D., P.C is not allowed to divulge medical o financial information to anyone other than the patient (of guardian in the case of a minor) unless explici authorization is given

To authorize the David J. Gray, M.C., P.C. to discuss your medical information with someone other than yoursel please fill in below.

I, ______________________________ give David J. Gray, M.D., P. C. permission to release/discuss personal medical and/or financial information to/with:

Name of Person	Relationship to Patient	Phone #

_______________________ _______________

Signature of Patient Date

Date:_______________

Patient's Name:__________________________________
Date of Birth:____/ ____/____ Age: ____
Male [ ] Female [ ]
Single [ ] Married [ ] Divorced [ ] Other [ ]
Family Physician:_________________________________
Referring Physician:_______________________________

Reason for Visit:

____
____
____

Past Medical Problems:

____
____
____

Past Surgeries:

____
____
____

Family Medical Problems:

____
____
____

Medications:

____
____
____

Do you take Aspirin or Anti-inflammatory medications? Yes [ ] No [ ]

Allergies: _______________________________________

Social History:
Occupation:______________________________________
Have you ever smoke? No [ ] Yes[ ] Packs per day__________
Alcohol use No [ ] Yes [ ] Drinks per week____________

Female Medical History:

Are you pregnant? Yes [ ] No [ ]

Birth control method:___________

Last menstrual period:__________

Number of pregnancies:_________

Number of children:____________

Did you breastfeed?____________

Review of Systems:

Do you any problems with the following?

Eyes/Ears		***Nose/Throat***	
Glaucoma	Yes/No	Hoarness	Yes/No
Cataracts	Yes/No	Voice changes	Yes/No
Glasses/contacts	Yes/No	Nose Bleeds	Yes/No
Hearing aids	Yes/No	Thyroid	Yes/No
Heart		***Lungs***	
Chest pain	Yes/No	Asthma	Yes/No
Irregular beats	Yes/No	Wheezing	Yes/No
High blood pressure	Yes/No	Shortness of breath	Yes/No
GI		***GU***	
Ulcers	Yes/No	Blood in urine	Yes/No
Pancratitis	Yes/No	Frequent urination	Yes/No
Gall bladder	Yes/No	Urination at night	Yes/No
Colitis	Yes/No	Trouble starting	Yes/No
Blood in stool	Yes/No	Trouble stopping	Yes/No
Hiatal hernia	Yes/No	Pain	Yes/No
Liver	Yes/No		
Endocrine		***Psychiatric***	
Diabetes	Yes/No	Depression	Yes/No
Low blood sugar	Yes/No	Anxiety	Yes/No
Hormone problems	Yes/No		
Skin		***Neurologic***	
Infections	Yes/No	Headaches	Yes/No
Psoriasis	Yes/No	Seizures	Yes/No
Cancer	Yes/No	Strokes	Yes/No
Immunologic		***Bleeding***	
Allergies	Yes/No	Anemia	Yes/No
		Bleeding problems	Yes/No

Any other medical problems?

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