Grace Medical & Allergy

Patient Registration Form

First Name	Last Name	DOB (MM/DD/YYYY)
Male ☐ Female ☐ Sex (Check one)	Race	Employment Status
Street Address	City	State Zip
Home Phone	Cell Phone	Email
Email ☐ Text ☐ Electronic Preference (Check one or both)	Mail ☐ Email ☐ Written Contact Preference (Check one)	

Primary Reason for Visit

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No._____

Address: _____

Practice Name: Grace Medical & Allergy.

I have been offered a copy of Grace Medical & Allergy's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Grace Medical & Allergy has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Official, or by visiting the Practice web site at www.gracemedicaloffice.com.

My signature below acknowledges that I have been offered a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Practice Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____
Signature of Practice Representative Date

_____
Print Name

FILE ORIGINAL IN PATIENT'S BUSINESS OFFICE RECORD.

Authorization to Bill Health Insurance/Assignment of Benefits

By signing below, I authorize Dr. Lawrence Alan Whaley, MD to bill my insurance company for services rendered. I also agree to have any checks or payment made by my insurance company to be payable and deliverable to:

Dr. Lawrence Alan Whaley, MD

671 NE Alsbury Blvd STE B,

Burleson, TX 76028.

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Dr. Whaley, for correct billing. I am also responsible to notify Dr. Whaley in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

Print name:_____ Date_____

Signature_____

GRACE MEDICAL & ALLERGY

Dr. Lawrence Alan Whaley, MD.

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems ..... ☐ Y ☐ N
Arthritis ..... ☐ Y ☐ N
Bleeding/Clotting Disorder..... ☐ Y ☐ N
Blood Pressure Disorder ..... ☐ Y ☐ N
Blood Transfusion ..... ☐ Y ☐ N
Bowel/Stomach Problems ..... ☐ Y ☐ N
Cancer ..... ☐ Y ☐ N
Cholesterol Disorder ..... ☐ Y ☐ N
Diabetes ..... ☐ Y ☐ N
Eye Disorder (i.e. Glaucoma, cataract) ..... ☐ Y ☐ N
If Relevant: Gynecological Issues..... ☐ Y ☐ N

Heart Disease/Disorder ..... ☐ Y ☐ N
Lung Disorder ..... ☐ Y ☐ N
Liver Disease ..... ☐ Y ☐ N
Neurological Disorder/Chronic Headaches .. ☐ Y ☐ N
Psychiatric Disorder/Illness ..... ☐ Y ☐ N
Pulmonary Embolism/DVT ..... ☐ Y ☐ N
Stroke ..... ☐ Y ☐ N
Seizure or Epilepsy ..... ☐ Y ☐ N
Thyroid Disorder ..... ☐ Y ☐ N
Urinary/Kidney Disorder ..... ☐ Y ☐ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list any relevant past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	

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info@Gracemedicaloffice.com

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked _____ Packs/day_____
Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week:

If Relevant: Any past pregnancies? □ Y □ N How many? ___ How many deliveries? ____

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Allergy	Reaction

Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

Constitutional

□Y□N Fever
□Y□N Chills
□Y□N Fatigue
□Y□N Feeling Poorly
□Y□N Sweats
□Y□N Weight Gain (___Lbs)
□Y□N Weight Loss (___Lbs)
□Y□N Unexp. Weight Change
□Y□N Sleep Disturbances
□ Other:

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem
□Y□N Decreased Hearing
□Y□N Double Vision
□Y□N Light Sensitivity
□Y□N Itchy Eyes
□Y□N Red Eyes
□Y□N Eye Pain
□Y□N Runny Nose
□Y□N Neck Stiffness
□Y□N Nosebleed
□Y□N Congestion
□Y□N Snoring
□Y□N Dry Mouth
□Y□N Flu-Like Symptoms
□Y□N Sore Throat
□Y□N Hoarseness
□Y□N Ringing in Ears
□Y□N Vertigo
□Y□N Earache
□Y□N Other:

Cardiovascular

□Y□N Chest Pain
□Y□N Palpitations
□Y□N Leg Swelling
□Y□N Cold Extremities
□Y□N Cold Hands or Feet
□Y□N Leg Pain w/ Walking
□Y□N Irregular Heart Rhythm
□Y□N Other:

Respiratory

□Y□N Shortness of Breath
□Y□N Cough
□Y□N Rapid Breathing
□Y□N Wheezing
□Y□N Shortness of Breath
□Y□N Chest Congestion
□Y□N Coughing Up Blood
□Y□N Coughing Up Sputum
□ Other:

Gastrointestinal

□Y□N Abdominal Pain	□Y□N Diarrhea	□Y□N Change in Bowels	□Y□N Painful Swallowing
□Y□N Blood in Stool	□Y□N Black/Tarry Stools	□Y□N Vomiting Blood	□ Other:
□Y□N Vomiting	□Y□N Decreased Appetite	□Y□N Bowel Incontinence	
□Y□N Nausea	□Y□N Yellow Skin	□Y□N Rectal Pain	
□Y□N Constipation	□Y□N Trouble Swallowing	□Y□N Heartburn	

Neurological

□Y□N Headache	□Y□N Unsteady	□Y□N Numbness	□Y□N Tremor
□Y□N Dizziness	□Y□N Disorientation	□Y□N Tingling	□Y□N Memory Lapses/Loss
□Y□N Decreased Strength	□Y□N Confusion	□Y□N Seizures	□ Other:
□Y□N Poor Coordination	□Y□N Burning Sensation	□Y□N Fainting (Syncope)	

Musculoskeletal

□Y□N Joint Pain	□Y□N Limb Pain	□Y□N Muscle Pain	□ Other:
□Y□N Neck Pain	□Y□N Joint Swelling	□Y□N Muscle Weakness	
□Y□N Back Pain	□Y□N Muscle Cramps	□Y□N Leg Swelling	

Genitourinary

□Y□N Frequent Urination	□Y□N Pelvic Pain	□Y□N Painful Intercourse	□Y□N Heavy Period Bleeding
□Y□N Incontinence	□Y□N Nocturia	□Y□N Discharge- Vaginal	□ Other:
□Y□N Urinary Urgency	□Y□N Itching- Genital	□Y□N Vaginal Bleeding	
□Y□N Painful Urination	□Y□N Change in Libido	□Y□N Irreg. Monthly Cycles	

Integumentary

□Y□N Rash	□Y□N Skin Wound	□Y□N Unusual Growth	□Y□N Skin Cancer
□Y□N Dry Skin	□Y□N Change in A Mole	□Y□N Itching	□ Other:

Psychiatric

□Y□N Depression	□Y□N Anxiety	□Other:

Hematologic/Lymphatic

□Y□N Easy Bruising	□Y□N Easy Bleeding	□Y□N Swollen Lymph Nodes	□ Other:

Endocrine

□Y□N Excessive Thirst	□Y□N Heat Intolerance	□Y□N Changes- Skin
□Y□N Cold Intolerance	□Y□N Changes- Hair	□ Other:

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