DR. MELISSA GRAVES
MEDICATION LOG

PATIENT NAME _____ DOB _____
PHARMACY _____

MEDICATION	DOSE/FREQUENCY	SPECIAL NOTES

Dr. Melissa Graves Office

Patient Information:

First Name: _____ **MI:** _____**Last Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SS#:_____ **Date of Birth:** _____ **Age:** _____

Phone #:_____**Cell Phone:** _____ **Marital Status: S M D W**

Employer: _____ **Work #:**_____

HIPPA PRIVACY ACT

Please list the names of people that you authorize us leave/release your medical information with other than yourself.

Name:_____ **Relationship**_____ **Phone**_____

Name:_____ **Relationship**_____ **Phone**_____

Emergency Contact _____**Relationship**_____ _____
Phone #_____
Can we leave message on answering machine? Yes_____ **No** _____
Pharmacy_____ **Phone #** _____

Responsible Party: (please complete if INSURANCE/GUARANTOR is in another name.)
Name: _____ Relation:_____
Address:_____ City:_____ State:_____ Zip:_____
SS#: _____ Date of Birth:_____

IF NO INSURNACE INFORMATION IS OBTAINED AT THE TIME OF SERVICE THE PATIENT WILL BE CONSIDERED A SELF-PAY AND PAYMENT WILL BE DUE AT THE TIME OF SERVICE.

PATIENT CONSENT:

I consent to the release of protected health information that is required to carry out treatment and payment for healthcare services performed on my behalf. I also consent to all treatments as deemed appropriate by treating physician and agree to pay for all such services rendered and/or authorize my insurance company to pay Dr. Graves directly. I accept responsibility for payment for all charges incurred as well as all collections agency costs and attorney fees should such action become necessary. I further attest that I have read and understand the Notice of Privacy Practices.

Signature_____ **Date:**_____

Melissa D. Graves, M.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Melissa D Graves

Address: 167 S Mineral St. Suite 200

City: Keyser State: WV Zip Code: 26726

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

I Understand the following:

- **My health record(s) will not be released or obtained by Dr. Melissa Graves unless permission is granted by my signature on this authorization.**
- **Only the records checked above will be released for the above-stated reason(s)**
- **Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, Dr. Melissa Graves has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA privacy Rule.**
- **I am entitled to a copy of this completed authorization form.**
- **This authorization is valid for one year from the date of the signature, unless a specific timeframe less than one year is documented----Specific timeframe for validity.**
- **I have the right to revoke this authorization at any time by sending a written request to the office.**
- **By revoking this authorization,**
  - **My decision to revoke the authorization does not apply to any release of PHI that may have taken place prior to the date of the revocation request.**
  - **My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care. As a result, I may be liable for payment of the claim.**

Photocopies are provided by a contractual copy service that will invoice the requestor directly. Federal and state laws indicate that a reasonable, cost-based fee may be charged for copies of health care records. Copies of my records that are provided for my continued care will be mailed to my physician at no charge.

Signature:_____ Date:_____

Mailed:_____ or Faxed:_____ Initials:_____

Melissa D. Loya, M.D.

167 S. Mineral Street
Suite 200
Keyser, WV 26726
Phone: 304-597-2494
Fax: 304-597-2497

PEDIATRIC INTAKE FORM

Patient's Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone (home): _____ (Parent's work): _____
Parent's email address: _____
Age: _____ Date of Birth: _____ Gender: Female / Male
How did you hear about this clinic? _____
Has any other family member already been a patient at this clinic? _____
Name of doctor's office/hospital/clinic where your child's health records are kept: _____
_____
Reason for referral or presenting problems: _____

MEDICATIONS

NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamine
____	____	Antibiotics	____	____	Other _____
____	____	Ibuprofen	Allergies to medicines: _____		

MEDICAL HISTORY

____ Chicken pox	____ Scarlet fever	____ Tonsillitis, approx no. of times: _____
____ Measles	____ Pneumonia	____ Ear infections, approx no. of times: _____
____ Mumps	____ Frequent colds	____ Strep throat, approx no. of times: _____
____ Rubella	____ Rheumatic fever	____ Other: _____

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): _____
Psychological evaluations: _____
Hearing test: _____
Speech/language tests: _____
Injuries/surgeries/hospitalizations (please list): _____

IMMUNIZATIONS

____ MMR	____ DPT	____ Chicken pox Others: _____
____ Measles	____ Diphtheria	____ Small pox Adverse reactions: Y / N
____ Mumps	____ Tetanus	____ H. influenza If so, what? _____
____ Rubella	____ Polio	____ The flu _____

FAMILY HISTORY

____ Heart disease	____ Diabetes	____ Birth defects
____ Hypertension	____ Arthritis	____ Tuberculosis
____ Cancer	____ Allergies	____ Asthma
____ Mental illness	____ Osteoporosis	____ Other significant: _____

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PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

_____

Mother's age at child's birth: _____

Mother's health during pregnancy:

____ Bleeding	____ Nausea	____ Physical or emotional trauma
____ Illnesses	____ Hypertension	____ Cigarettes, alcohol, drug consumption
____ Medications	____ Diabetes	____ Thyroid problems

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Late Weight at birth: _____

Length of labor: _____ Complications: _____

Did you child have any of the following problems shortly after birth?

____ Rashes	____ Birth injuries	____ Blue baby
____ Jaundice	____ Seizures	____ Cerebral palsy
____ Colic	____ Fever	____ Birth defects

____ Other:

_____

Child's sleep patterns (1st year): _____

Food intolerances: _____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy):_____

Age began solids: _____ Which foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

____ Hives	____ Burning urine	____ Bloody urine	____ Eczema
____ Cries easily	____ Bleeding gums	____ Heart murmur	____ Nervous
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Asthma
____ Acne	____ Anemia	____ Night sweats	____ High fevers
____ Jaundice	____ Sensitive to light	____ Chronic rash	____ Stomach aches
____ Diarrhea	____ Hearing loss	____ Easy bruising	____ Sore throats
____ Flat feet	____ No appetite	____ Body/breath odor	____ Constipation
____ Nightmares	____ Frequent colds	____ Bleeding tendency	____ Unusual fears
____ Wheezing	____ Joint pains	____ Excessive fatigue	____ Cough
____ Dizzy spells	____ Hair loss	____ Frequent urination	____ Allergies

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.