

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: _____