Print Form

A Daniel Greco, M.D., PLLC **Patient History Form**

_____ _____ _____ ○ Male
Last Name First Name Middle Initial ○ Female

_____ _____ _____
Date of Birth Age Occupation/Employer

_____ _____
Referring Physician Primary Physician

_____
Why are you here?

_____
Symptoms and date of onset.

_____
List any X Rays, Special Procedures or Blood tests done for this problem.

_____
If you were treated for this problem in the past, please supply dates and outcomes.

_____
List previous surgeries, hospitalizations, and serious injuries. (Please specify disease and dates in line provided)

○ Heart Disease _____ ○ Implanted Parts (Joint Replacement or Pacemaker) ○ Colonoscopy _____
○ Bypass or Stent ○ Cancer ○ EGD
○ Other: _____

Do you take medicines (including aspirin, herbals ad non prescription drugs)? ○ Yes ○ No
If yes to either question, please fill out supplementary Medicine and Allergy form.

Your Social History – Check all that apply

Marital Status	○ Single	○ Married	○ Separated	○ Divorced	○ Widowed
Alcohol use	○ Never	○ Rarely	○ Moderately	○ Daily	○ In Recovery
Tobacco use	○ Never	○ Former	○ Yes	If yes, pack/day _____	
Drug Use	○ Never	○ Yes	○ If yes, type(s) and frequency _____		
Work exposure	○ Fumes	○ Dust	○ Solvents	○ Noise	○ Other (explain) _____

Your Medical History – Check all that apply

○ Diabetes	○ High Blood Pressure	○ Stroke/TIA	○ Anesthesia Problems
○ Seizures	○ Thyroid disease	○ Colon polyps	○ Other: _____
○ Tuberculosis	○ Hereditary defect	○ Arthritis/Gout	○ Other: _____ _____
○ Long bleeding	○ HIV/AIDS	○ Venereal disease	○ Other: _____
○ Lung disease	○ High Cholesterol	○ Vascular Disease	○ Other: _____

Family History - Check all that apply (Members of your immediate family: M-Mother, F-Father, GP- Grandparent, S-Sibling. Please indicate by code on line provided.) (Are they Alive or Deceased & age.)

Cancer of: ○ Breast ○ Lung ○ Colon ○ Ovary ○ Stomach ○ Pancreases ○ Bladder ○ Other: _____
Who: _____ _____ _____ _____ _____ _____ _____ _____

Medical: ○ High blood pressure ○ Heart disease ○ Diabetes ○ Colon polyps ○ Bleeding disorder ○ Anesthesia problems
Who: _____ _____ _____ _____ _____ _____

Patient Name _____

Constitutional
- ○ Recent weight loss/gain_____
- ○ Fever >101
- ○ Fatigue
- ○ Chills
- ○ Sleep problems
- ○ Night sweats

Eyes
- ○ Glasses or Contacts
- ○ Disease/Injury
- ○ Blurred double vision
- ○ Sudden change in vision

Ears, Nose, Throat
- ○ Hearing loss
- ○ Hearing aid
- ○ Earache or drainage
- ○ Ears ringing
- ○ Nose bleeds
- ○ Mouth sores
- ○ Bleeding gums
- ○ Bad breath/taste
- ○ Voice change
- ○ Sinus problems
- ○ Enlarged neck glands

Cardiovascular
- ○ Heart trouble
- ○ Chest pain
- ○ Irregular heartbeat or pacemaker
- ○ Leg, foot swelling
- ○ Pacemaker

Respiratory
- ○ Sleep apnea
- ○ CPAP use
- ○ Frequent cough
- ○ Spitting up blood
- ○ Short of breath
- ○ Asthma/wheeze
- ○ Snoring

Gastrointestinal
- ○ Bowel movements _____
- ○ Loss of appetite
- ○ Change in bowl movement's
- ○ Frequent diarrhea
- ○ Red blood in bowel movement
- ○ Black bowel movement
- ○ Abdominal pain
- ○ Pale or clay colored stools
- ○ Food intolerance(s)
- ○ Hard swallowing
- ○ Yellow skin
- ○ Heartburn
- ○ Painful bowel movement

Genitourinary
- ○ Frequency
- ○ Burning
- ○ Painful urination
- ○ Blood in urine
- ○ Decreased force
- ○ Dribbling
- ○ Sexual difficulty
- ○ M – Testicle pain
- ○ F – Painful menses
- ○ F – Irregular period
- ○ F – Vaginal discharge
- ○ LMP_____
- ○ Menopause
- ○ Contraception use

Musculoskeletal
- ○ Joint pain
- ○ Joint stiffness
- ○ Joint swelling
- ○ Muscle pain
- ○ Weakness
- ○ Back pain
- ○ Cold hands/feet
- ○ Difficulty walking

Skin and Breast
- ○ Rash or itching _____
- ○ Change in hair/nails
- ○ Varicose veins
- ○ Nausea/vomiting
- ○ Change in skin/mole _____
- ○ Breast pain
- ○ Breast lump
- ○ Breast discharge
- ○ Jaundice/Yellow skin

Neurological
- ○ Frequent headache
- ○ Light headed
- ○ Numbness/Tingling
- ○ Paralysis
- ○ Memory loss
- ○ Tremors
- ○ Arm or leg weakness
- ○ Fainting
- ○ Serious mental disorder _____

Psychiatric
- ○ Panic attack
- ○ Anxiety
- ○ Depression

Endocrine
- ○ Hair loss
- ○ Excessive thirst or urination
- ○ Heat or cold intolerance

Hematological/Lymphatic
- ○ Easy bruising or prolonged bleeding
- ○ Anemia
- ○ Blood clots
- ○ Prior blood transfusion(s)
- ○ Enlarged lymph nodes

Current Height _____

Current Weight _____

Supplemental oxygen therapy
Frequency _____
Liter flow _____

Explanation(s) for any of the check marked above. _____

Where do you usually have lab tests performed? _____

Where do you usually have X-Rrays done? _____

Have you had labs tests or X-Rays within the last 3 months? ○ Yes ○ No _____ Specialist _____

Have you had and EKG or Chest X-Ray within the last 3 months? ○ Yes ○ No _____ Cardiologist _____

_____ _____

Patient Signature Physician Signature

Last Name _____ First Name _____ Middle Initial _____ Sex _____

Local Pharmacy Name and Location _____

List all prescription and over the counter medications including frequency and dose.

	Medication	Frequency	Dose		Medication	Frequency	Dose
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Please include all over the counter drugs such as Tylenol, Aspirin, dietary supplements and herbal preparations in the space below.

Allergies – List all that you know and explain the reaction. **If no known medication allergies please check here.** ○ **(KNDA)**

Antibiotics ○ _____

Anesthetics ○ _____

Antiseptics ○ _____

Pain Killers ○ _____

Food ○ _____

Other ○ _____

_____ _____

Patient Signature Date

A Daniel Greco, M.D., PLLC **Patient Registration Form**

Last Name _____ First Name _____ MI _____ Sex _____

Other names used in past _____ Preferred Name _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Date of Birth _____ SSN _____ Age _____ Marital Status _____ Race _____ Hispanic Y/N _____ Religion _____ Language _____

Occupation _____ Employer _____ Employer Address/Phone _____

Home Phone _____ Cell Phone _____ Work Phone _____

Last Name of Spouse of Significant Other/Parent _____ First Name and Relationship _____ Date of Birth _____ Phone _____

Primary Care Physician _____ Telephone # _____ Referring Physician _____ Telephone # _____

Who to contact in an emergency _____ Relationship _____ Telephone # _____

Primary Insurance Company Name _____ Policy Number _____

Subscriber Last Name _____ First Name _____ Date of Birth _____ SSN _____

Street Address _____ City _____ State _____ Zip _____

Relationship to Patient _____ Telephone # _____ Occupation _____ Employer _____

Secondary Insurance Company Name _____ Policy Number _____

Subscriber Last Name _____ First Name _____ Date of Birth _____ SSN _____

Street Address _____ City _____ State _____ Zip _____

Relationship to Patient _____ Telephone # _____ Occupation _____ Employer _____

I consent to and authorize treatment for the above named patient. I authorize the release of any information by healthcare professionals participating in my care of the care of a minor whom I am responsible for.

Patient signature (or parent or legal guardian of minor) _____ Relationship to patient _____ Date _____

A Daniel Greco, M.D., PLLC

Notice of Privacy Practiced Acknowledgment and Financial Policy

Patient Name _____ DOB _____

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow – up among the multiple healthcare providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third – party payors;
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have read and understand your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information, I understand that this practice has the right to change its notices of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care options. I also understand that you are not required to agree to requested restrictions but that if you do agree, you are bound to abide by such restrictions.

Individuals with whom I authorize A. Daniel Greco, M.D., PLLC and/or its representatives to discuss:

- ○ Medical Information
- ○ Financial Information
- ○ Appointments

_____
Name

_____
Relationship

- ○ Medical Information
- ○ Financial Information
- ○ Appointments

_____
Name

_____
Relationship

Financial Policy

1. Payment is due at time of service unless other arrangements have been made previously. We accept cash, check, MasterCard and Visa.
2. Your insurance is a contract between you and your insurance company. We will file your claim with your insurance company if you assign the benefits to the physician. If your insurance does not pay the practice within a reasonable amount of time, we will look to you for payment. If we later receive a check from your insurance company, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance c companies to accept an assignment of benefits. We will bill them and you are required to pay you co-payment and any cost share at the time of the visit.
4. Not all insurance companies cover all services. In the event your insurance plan determines service to be “non-covered” you will be responsible for the full charge. Payment is due upon receipt of a statement from our biller.
5. We will bill your insurance company for physician services provided in the hospital or surgery center. You may be expected to prepay a portion or entire fee of elective surgical procedures in the case of certain deductible plans of If you are a cash-pay patient. Our financial counselor will provide payment details at the time of scheduling your surgery. Payment plans can be arranged.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Signature of patient (of Responsible Party) Date