

DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

FIRST NAME/  
MIDDLE INITIAL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

OTHER PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

SEX: Male Female

MARITAL STATUS: Single Married Widowed Divorced Separated

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

NAME OF SPOUSE/PARENT/ GUARDIAN/RELATIVE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ SPOUSE DATE OF BIRTH (for insurance purposes) : \_\_\_\_\_

### MEDICAL HISTORY

WHAT ARE YOU BEING SEEN FOR TODAY? *PLEASE CIRCLE ALL THAT APPLY*

**RIGHT:** Shoulder Elbow Wrist Hand Finger ( thumb index middle ring, small) Hip Knee Leg Ankle Foot Toe (1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup>)

**LEFT:** Shoulder Elbow Wrist Hand Finger (thumb index middle ring, small) Hip Knee Leg Ankle Foot Toe (1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup>)

BACK (upper middle lower) NECK RIBS OTHER: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ **OR** HOW LONG HAVE YOU HAD THIS PROBLEM? \_\_\_\_\_ days weeks months years

HOW DID THIS PROBLEM OCCUR? \_\_\_\_\_

IF INJURED, WHERE DID YOU INJURE YOURSELF? Home School Work Auto Sports Other: \_\_\_\_\_

WERE YOU SEEN AT AN EMERGENCY ROOM? Yes No WHEN? \_\_\_\_\_

WHERE? \_\_\_\_\_ WERE XRAYS TAKEN? Yes No

PLEASE LIST THE PHYSICIANS YOU ARE TREATING WITH:

1. FAMILY DOCTOR / PRIMARY CARE PHYSICIAN \_\_\_\_\_
2. SPECIALIST(S) \_\_\_\_\_
3. OTHER \_\_\_\_\_

PLEASE LIST ANY ALLERGIES YOU HAVE: \_\_\_\_\_

PLEASE LIST ANY/ALL MEDICATIONS OR DRUGS YOU ARE NOW TAKING, INCLUDING OVER-THE-COUNTER MEDICATIONS, HERBAL MEDICATIONS AND VITAMINS:

WHAT ARE YOU TAKING THESE MEDICATIONS FOR? \_\_\_\_\_

PLEASE LIST YOUR PHARMACY ADDRESS AND TELEPHONE #:

ARE YOU CLAUSTROPHOBIC? Yes No DO YOU REQUIRE MEDICATION FOR DIAGNOSTIC TESTING? Yes No

**PAST MEDICAL HISTORY**

<i>HOSPITALIZATIONS</i>	<i>DESCRIPTION</i>	<i>YEAR</i>	<i>HOSPITAL</i>
ILLNESS	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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SURGERIES	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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OTHER (REASON)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

ARE YOU NOW OR HAVE YOU BEEN UNDER A DOCTOR'S CARE FOR A SERIOUS ILLNESS OR CONDITION? Yes No

PLEASE LIST ILLNESS/CONDITION: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL/HEALTH RISK HISTORY**

- Yes No  
\_\_\_ DO YOU SMOKE? HOW MANY CIGARETTES/PACKS PER DAY? \_\_\_\_\_  
\_\_\_ DO YOU USE ALCOHOL? IF YES, PLEASE CIRCLE: OCCASIONAL MODERATE HEAVY  
\_\_\_ DO YOU USE SEATBELTS?  
\_\_\_ DO YOU EXERCISE? WHAT TYPE OF ACTIVITY? \_\_\_\_\_  
\_\_\_ ARE YOU EXPOSED TO WORK HAZARDS AT YOUR PLACE OF EMPLOYMENT?  
\_\_\_ DO YOU HAVE A DIET OR EATING DISORDER?

WHO DO YOU PRESENTLY LIVE WITH? SELF SPOUSE FAMILY OTHER: \_\_\_\_\_

**FAMILY HISTORY**

IF YOU ARE ADOPTED, PLEASE CHECK HERE AND SKIP TO THE NEXT SECTION: \_\_\_\_\_

HAS ANYONE IN YOUR IMMEDIATE FAMILY EVER HAD THE FOLLOWING? YES NO  
IF YES, PLEASE CIRCLE FAMILY MEMBER

- |  |        |            |           |            |
|--|--------|------------|-----------|------------|
| ___ Heart Attack/Heart Disease/Surgery | Father | Mother     | Sister(s) | Brother(s) |
| ___ High Blood Pressure/Cholesterol    | Father | Mother     | Sister(s) | Brother(s) |
| ___ Breast/Ovarian/Uterine Cancer      | Mother | Sister (s) |           |            |
| ___ Prostate Cancer                    | Father | Brother(s) |           |            |
| ___ Other Cancer                       | Father | Mother     | Sister(s) | Brother(s) |
| ___ Diabetes (Insulin Dependent)       | Father | Mother     | Sister(s) | Brother(s) |
| ___ No longer living                   | Father | Mother     | Sister(s) | Brother(s) |

## REVIEW OF SYSTEMS

### Genitourinary

Yes No  
\_\_\_ \_\_\_ Frequent bladder infections  
\_\_\_ \_\_\_ Bladder, urinary or kidney problems  
\_\_\_ \_\_\_ Abnormal Pap Smear  
\_\_\_ \_\_\_ Abnormality of uterus  
\_\_\_ \_\_\_ Pelvic infection/pain (PID)  
\_\_\_ \_\_\_ Recurrent vaginal infection  
\_\_\_ \_\_\_ Sexually transmitted disease  
\_\_\_ \_\_\_ Breast problems  
\_\_\_ \_\_\_ Prostate problems  
\_\_\_ \_\_\_ Colon Problems

### Cardiovascular

Yes No  
\_\_\_ \_\_\_ Chest pain  
\_\_\_ \_\_\_ Heart disease/murmur  
\_\_\_ \_\_\_ High blood pressure  
\_\_\_ \_\_\_ High cholesterol/Triglycerides  
\_\_\_ \_\_\_ Thrombophlebitis/blood clots  
\_\_\_ \_\_\_ in veins or lungs  
\_\_\_ \_\_\_ Shortness of breath

### Gastrointestinal

Yes No  
\_\_\_ \_\_\_ Stomach problems  
\_\_\_ \_\_\_ Liver disease/jaundice  
\_\_\_ \_\_\_ Hepatitis  
\_\_\_ \_\_\_ Gall bladder disease  
\_\_\_ \_\_\_ Ulcers  
\_\_\_ \_\_\_ Diarrhea  
\_\_\_ \_\_\_ Bowel/bladder problems

### General

Yes No  
\_\_\_ \_\_\_ My health is generally good  
\_\_\_ \_\_\_ Recent weight gain/loss  
\_\_\_ \_\_\_ Frequent colds/flu  
\_\_\_ \_\_\_ Chronic fatigue (> 6 mos)  
\_\_\_ \_\_\_ Cancer \_\_\_\_\_  
\_\_\_ \_\_\_ Genetic condition

### Neurologic

Yes No  
\_\_\_ \_\_\_ Migraine headaches  
\_\_\_ \_\_\_ Sensory difficulties  
(numbness, hearing, taste, smell)  
\_\_\_ \_\_\_ Stroke  
\_\_\_ \_\_\_ Seizures/Epilepsy

### Ears, Nose, Throat, Mouth

Yes No  
\_\_\_ \_\_\_ Hearing aid  
\_\_\_ \_\_\_ Hearing problems  
\_\_\_ \_\_\_ Dentures  
\_\_\_ \_\_\_ Teeth/Gum problems  
\_\_\_ \_\_\_ Frequent nosebleeds

### Musculoskeletal

Yes No  
\_\_\_ \_\_\_ Broken bones/fractures  
\_\_\_ \_\_\_ Total joint replacements  
\_\_\_ \_\_\_ Joint pain/bone pain  
\_\_\_ \_\_\_ Arthritis/tendinitis

### Eyes

Yes No  
\_\_\_ \_\_\_ Glasses  
\_\_\_ \_\_\_ Glaucoma  
\_\_\_ \_\_\_ Loss of vision  
\_\_\_ \_\_\_ Other eye problems

### Psychology

Yes No  
\_\_\_ \_\_\_ Depression  
\_\_\_ \_\_\_ Anxiety  
\_\_\_ \_\_\_ Severe mood swings  
\_\_\_ \_\_\_ Under care of physician

### Hematologic

Yes No  
\_\_\_ \_\_\_ Anemia  
\_\_\_ \_\_\_ Blood clotting disorder  
\_\_\_ \_\_\_ Blood transfusion  
\_\_\_ \_\_\_ Sickle Cell Anemia/Trait/Thallemia

### Endocrine

Yes No  
\_\_\_ \_\_\_ Diabetes/Diabetes of  
pregnancy  
\_\_\_ \_\_\_ Thyroid problems  
\_\_\_ \_\_\_ Asthma

### Immunizations

Yes No  
\_\_\_ \_\_\_ Rubella (German measles)  
\_\_\_ \_\_\_ Chicken pox  
\_\_\_ \_\_\_ Tetanus

### Skin

Yes No  
\_\_\_ \_\_\_ Acne  
\_\_\_ \_\_\_ Chronic rash/itching  
\_\_\_ \_\_\_ Eczema/Psoriasis

### Respiratory

Yes No  
\_\_\_ \_\_\_ Chronic cough  
\_\_\_ \_\_\_ Other breathing problems

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## INSURANCE COVERAGE

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_ POLICY #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Effective date: \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_ POLICY #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Effective date: \_\_\_\_\_

OTHER INSURANCE COMPANY NAME: \_\_\_\_\_ POLICY #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Effective date: \_\_\_\_\_

## WORKERS' COMPENSATION

EMPLOYER: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

INJURY REPORTED TO EMPLOYER? Yes No ARE YOU PRESENTLY WORKING? Yes No Full Duty Light/Modified Duty

## LIABILITY - (Auto / Slip & Fall)

TYPE: \_\_\_\_\_ WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_

IF AUTO ACCIDENT, WERE YOU THE PASSENGER OR DRIVER? \_\_\_\_\_

INSURANCE COMPANY NAME/ADDRESS: \_\_\_\_\_

## CONSENT TO TREATMENT

I hereby consent to the rendering of care by Franklin E. Mirrer, M.D., 215 Tollgate Road, Warwick, RI, 02886, which may include laboratory testing and other procedures, and such medical treatment as my Physician(s) or other Provider(s) consider to be necessary or advisable.

Patient will be responsible for bills to be paid at the time of service unless arrangements are made. A statement for professional services will be rendered.

**NOTE:** *It is to be understood that any payment received from a third party, such as insurance companies, will be credited to your account and you will be personally liable for any unpaid balances after a 30 day period. I understand that if I do not pay any amount which is owed to you within 30 days after receipt of your statement for services rendered, I will be in default of this agreement and I will pay any and all reasonable attorney fees, to the extent permitted by law.*

I hereby authorize **Franklin E. Mirrer, M.D.** ( the "Medical Practice") to release and/or transfer all records, opinions, reports, x-rays, laboratory tests and analyses, photostatic copies, abstracts of excerpts of any medical records or other information of any kind relating to the undersigned in the possession of the Medical Practice (hereinafter collectively referred to as "Confidential Health Care Information"), including those results related to tests for HIV, for the purpose of coordinating my health care, and/or coordinating the payment of claims with my health insurer. Provided, however, that this Consent for Release of Confidential Health Care Information shall not apply to Confidential Health Care Information maintained in connection with the performance of any federally assisted alcohol and drug abuse problem.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for said doctor's additional protection.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
(Parent/Guardian must sign if patient is a minor)

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
(Parent/Guardian must sign if patient is a minor)

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
(Parent/Guardian must sign if patient is a minor)

### NOTICE OF PRIVACY PRACTICES

We maintain protocols to ensure the security & confidentiality of your personal information. We have physical security in our building, passwords to protect our databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. At this office, we are committed to treating & using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how & when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 & applies to all protected health information as defined by federal regulations. Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: Basis for planning your care & treatment; Means of communication among the many health professionals who contribute to your care; Legal document describing the care you received; Means by which you or a third-party payer can verify that services billed were actually provided; Tool in educating health professionals; Source of date for medical research; Source of information for public health officials charged to improve the health of the state & nation; Source of date for our planning & marketing; Tool by which we can assess and continually work to improve the care we render & outcomes we achieve.

Although your health record is the physical property of this office, the information belongs to you. You have the right to: Obtain a paper copy of this notice of privacy policies upon request; Inspect & obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law); Amend your health record as provided by 45 CFR 164.526; Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528; Request confidential communications of your health information as provided by 45 CFR 164.522(b) and request a restriction on certain uses & disclosures of your information as provided by 45 CFR 164.522(a) – [however, we are not required by law to agree to a requested restriction].

Our practice is required to: Maintain the privacy of your health information; Provide you with this notice as to our legal duties & privacy practices with respect to information we collect & maintain about you; Abide by the terms of this notice; Notify you if we are unable to agree to a requested restriction; Accommodate reasonable requests you may have to communicate your health information. We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not disclose your health information in a manner other than described in section regarding Examples of Disclosure for Treatment; Payment & Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b) (5), except to the extent that action has already been taken.

**Examples of Disclosure for Treatment, Payment & Health Operations:** *We will use your health information for treatment.* We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care. *We will use your health information for payment.* We may disclose your information so that we can collect or make payment for health care services you receive. *We may disclose your health information for our routine operations.* These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. **Consistent with applicable law, we may disclose medical information for the following:** to provide appointment reminders; to coroner, medical examiner or funeral directors; workers' compensation or other similar programs established by law; to public health or legal authorities charged with preventing or controlling disease, injury or disability; to researcher when their research has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal; to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation & transplant; as required by law for reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process or complying with the health oversight activities, such as audits, investigations & inspections necessary to ensure compliance with government regulations & civil rights laws; for military & veterans affairs or national security & intelligence activities; for services provided in our organization through contacts with business associates (ie – transcription services) due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do and to protect our health information we require the business associate to appropriately safeguard your information; to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement; for practice marketing to provide information about treatment alternatives or other health-related benefits & services that may be of interest to you; to your personal representative – or personal legally responsible for your care & authorized to act on your behalf in making decisions related to your health care; when we believe in good faith that your information is necessary to prevent a serious threat to your safety or that of another person – ie: – abuse, neglect, or domestic violence; to family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care – we may notify these individuals of your location/general condition; to an organization assisting in a disaster relief effort. **For all non-routine operations,** we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.

## CONSENT TO TREATMENT

I hereby consent to the rendering of care by **William F. Garrahan, M.D.**, 215 Tollgate Road, Warwick, RI, 02886, which may include laboratory testing and other procedures, and such medical treatment as my Physician(s) or other Provider(s) consider to be necessary or advisable.

Patient will be responsible for bills to be paid at the time of service unless arrangements are made. A statement for professional services will be rendered.

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I hereby authorize William F. Garrahan, M.D. ( the "Medical Practice") to release and/or transfer all records, opinions, reports, x-rays, laboratory tests and analyses, photostatic copies, abstracts of excerpts of any medical records or other information of any kind relating to the undersigned in the possession of the Medical Practice (hereinafter collectively referred to as "Confidential Health Care Information"), including those results related to tests for HIV, for the purpose of coordinating my health care, and/or coordinating the payment of claims with my health insurer. Provided, however, that this Consent for Release of Confidential Health Care Information shall not apply to Confidential Health Care Information maintained in connection with the performance of any federally assisted alcohol and drug abuse problem.

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DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
(Parent/Guardian must sign if patient is a minor)

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
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DATE: \_\_\_\_\_

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I hereby consent to the rendering of care by **Joseph E. Noonan, Jr., M.D.**, 215 Tollgate Road, Warwick, RI, 02886, which may include laboratory testing and other procedures, and such medical treatment as my Physician(s) or other Provider(s) consider to be necessary or advisable.

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SIGNATURE: \_\_\_\_\_  
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DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
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DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
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Although your health record is the physical property of this office, the information belongs to you. You have the right to: Obtain a paper copy of this notice of privacy policies upon request; Inspect & obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable copy fees apply in accordance with state law); Amend your health record as provided by 45 CFR 164.526; Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528; Request confidential communications of your health information as provided by 45 CFR 164.522(b) and request a restriction on certain uses & disclosures of your information as provided by 45 CFR 164.522(a) – [however, we are not required by law to agree to a requested restriction].

Our practice is required to: Maintain the privacy of your health information; Provide you with this notice as to our legal duties & privacy practices with respect to information we collect & maintain about you; Abide by the terms of this notice; Notify you if we are unable to agree to a requested restriction; Accommodate reasonable requests you may have to communicate your health information. We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not disclose your health information in a manner other than described in section regarding Examples of Disclosure for Treatment; Payment & Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b) (5), except to the extent that action has already been taken.

**Examples of Disclosure for Treatment, Payment & Health Operations:** *We will use your health information for treatment.* We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care. *We will use your health information for payment.* We may disclose your information so that we can collect or make payment for health care services you receive. *We may disclose your health information for our routine operations.* These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions. ***Consistent with applicable law, we may disclose medical information for the following:*** to provide appointment reminders; to coroner, medical examiner or funeral directors; workers' compensation or other similar programs established by law; to public health or legal authorities charged with preventing or controlling disease, injury or disability; to researcher when their research has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal; to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation & transplant; as required by law for reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process or complying with the health oversight activities, such as audits, investigations & inspections necessary to ensure compliance with government regulations & civil rights laws; for military & veterans affairs or national security & intelligence activities; for services provided in our organization through contacts with business associates (ie – transcription services) due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do and to protect our health information we require the business associate to appropriately safeguard your information; to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement; for practice marketing to provide information about treatment alternatives or other health-related benefits & services that may be of interest to you; to your personal representative – or personal legally responsible for your care & authorized to act on your behalf in making decisions related to your health care; when we believe in good faith that your information is necessary to prevent a serious threat to your safety or that of another person – ie: – abuse, neglect, or domestic violence; to family member or close personal friend health information relevant to that person's involvement in your care or payment related to your care – we may notify these individuals of your location/general condition; to an organization assisting in a disaster relief effort. ***For all non-routine operations,*** we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.