H. Raffi Balian, M.D., F.R.C.P.C

Physical Medicine and Rehabilitation

REGISTRATION FORM

Today's Date _____/_____/_____ Primary Care Physician____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone#: ( )

Cell Phone #:	Email:	Pharmacy:	Phone #:

Occupation	Employer	Employer Phone No. ( )

Referred to Office by (Please check one box) ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

Other Family Members Seen Here ____________________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize H. Raffi Balian, M.D. or insurance company to release any information required to process my claims.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

GENERAL MEDICAL INFORMATION

Describe the current medical problem / reason for today's visit: ______________________

Present medication: ______________________

Allergies to medication: ______________________

Allergies (e.g. itching or hives) to specific brands of soap / detergent / other: ______________________

Other physicians currently treating you: ______________________

Previous or other medical problems: ______________________

List any previous surgeries or hospitalizations: ______________________

____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No ❑ Cigarettes ❑ Pipe ❑ Cigars No of year's ______ How much ______

Interested in stopping? ❑ Yes ❑ No

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces / beers per day? ______________

Do you regularly drink coffee? ❑ Yes ❑ No How many cups per day? ______________

Are you under a lot of pressure at work? ❑ Yes ❑ No Please describe: ______________

PERSONAL MEDICAL INFORMATION

Have you ever had any of the following (check all that apply):

❑ Chest pain/pressure/tightening ___	❑ Asthma ______	❑ TB/Lung disorder ______
❑ Hypertension ______	❑ Dizzy spells ______	❑ Skin disorder ______
❑ Heart attack ______	❑ Cancer ______	❑ Hepatitis ______
❑ Stroke ______	❑ Diabetes ______	❑ Cataracts ______
❑ Headaches ______	❑ Arthritis ______	❑ Digestive problems ____
❑ Glaucoma ______	❑ Difficulty hearing ______	❑ Urinary infection ______
❑ Allergies or Eczema ______	❑Memory loss ______	❑ Blood in stool ______
❑ Depression ______	❑ Hemorrhoids ______	❑ Shortness of breath ______
❑ Ulcers ______	❑ Kidney disease ______	

FAMILY HISTORY

	Father	Mother	Grand Parents	Siblings	Children
High blood pressure	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Eczema / Psoriasis	❑	❑	❑	❑	❑
Heart Attack / Stroke	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:________________________ Signature________________________ Date______