PATIENT REGISTRATION

ACCT#____________

Name____ Birthdate___________ Age_____ Sex: M/F
(First) (MI) (Last)

Address____ SSN_________________
(Street) (City) (State) (Zip)

Home Ph.______________________ Cell Ph.____________________ Work Ph. ________________________

Email____

Race: ___Decline

__White/Caucasian

__Native Hawaiian/Other Pacific Islander

__Native American/Native Alaskan

__Black/African American

__Asian

__Other: _______________

Ethnicity: ___Decline

__Spanish/Hispanic Origin

__Not of Spanish/Hispanic Origin

Language: _____________________

Pharmacy Name: ______________________________________ Ph#/Location: _________________________

Primary Care Physician: _________________________________ Ph#_________________________________

Insured/Responsible Party (**if other than patient or patient under 18**)

Name_______________________________ Birthdate____________ SSN___________________

Relationship to Patient_______________ Daytime Ph.___________________________

Address (**if other than patient**) ____

Emergency Contact Person: ______________________________________ Home___________________

Relationship to Patient: _______________ Cell _____________________ Work___________________

If a life threatening emergency occurs while in our office, EMS will be called regardless of any advance directive

Are you currently working? YES NO ___Full Duty ___Lt Duty ___Retired __Not Employed

Are you currently off work due to this problem? YES NO What was your last day worked? _______________

Employer Name: ___________________________________ Occupation ____________________________

Employer Ph#____________________________

I was referred here by: __ DR: ___________________ __Website: ________________ __Phone book

__ Friend/Family Member __ Other: ________________________________

I am here today for my: __RT __ LT _____(Body Part)____

My pain/problem began on: ________________

This is a reoccurrence of an old problem: YES NO If yes, please explain: ______________________________

Have you been treated by any other doctor or facility for this problem? YES NO

If yes, please list doctors/facilities treated at: ____

Please list any medications tried for this problem? (including over the counter Advil, Aleve, etc.)

____

Is this the result of an injury? YES NO Is this the result of a Motor Vehicle Accident? YES NO

Is this the result of an injury at work? YES NO

IF YES:

Was your employer informed of your injury? YES NO Date employer informed: ___________

Have you filed an injury report with your employer or a first report of injury through Workmen's Comp? YES NO

Do you have an attorney? YES NO Attorney's Name: _________________________ PH: ________________

PATIENT NAME: _____________________________________ DOB __________________ ACCT# __________________

I AM: __RT HAND DOMINANT __LT HAND DOMINANT

Do you have a living will? YES NO If yes, who has a copy of it? _____________________________________

MY LAST BONE DENSITY WAS PERFORMED: __NEVER PERFORMED
ON/AROUND: _____________________ LOCATION/FACILITY: ____
(Please provide closest date possible)

PAST MEDICAL HISTORY

Do you currently have or have had any of the following:

__Diabetes	__Cancer	__Osteoporosis	__Fibromyalgia
__Arthritis	__Pacemaker	__Stroke	__High Blood Pressure
__Liver Problems	__Kidney Problems	__Stomach Ulcers	__Metal Implants
__Hypothyroidism	__Depression/Anxiety/Mental Disorders		__Post-Menopausal
__Breathing Problems	__Numbness/Tingling	__Stomach Problems	__Wound Healing Problems
__Weight Gain	__Weight Loss	__Heart Problems	__Blood Clots

___NONE OF THE ABOVE ___NONE OF THE ABOVE IN THE LAST 6 MONTHS

**If any of the above were checked, please explain: ____
____
**Other medical problems not listed above: ____

Have you ever had an operation for any medical problem? YES NO
Procedure: _______________________________________ Date or Year Performed ________________________
Procedure: _______________________________________ Date or Year Performed ________________________
Procedure: _______________________________________ Date or Year Performed ________________________
(**If you have had more than three procedures, please list any additional procedures on the back of this sheet)

Please check any assistive devices that may apply:
__Cane __Walker __Wheelchair __Glasses __Contacts __Dentures __Hearing Aid

FAMILY MEDICAL HISTORY

Do either of your parents **currently have or ever had** any of the following conditions?

MOTHER

__Diabetes	__Heart disease/condition	__High Blood Pressure	__ Kidney Disease
__Alzheimer's/Dementia	__ Cancer	__Stroke	

__Other: ____
__NONE OF THE ABOVE KNOWN

FATHER

__Diabetes	__Heart disease/condition	__High Blood Pressure	__ Kidney Disease
__Alzheimer's/Dementia	__ Cancer	__Stroke	

__Other: ____
__NONE OF THE ABOVE KNOWN

Do any other family members, siblings or children have any of the above conditions?? YES NO

PATIENT NAME_____________________________________ DOB___________________ ACCT#_________________

CURRENT HEIGHT: _____FT_____IN CURRENT WEIGHT: ____________LBS.

MEDICATIONS AND ALLERGIES

List all current medications you are taking:

___________________ _______________________ ______________________
___________________ _______________________ ______________________

Do you take blood thinners? (Aspirin, Coumadin, Ticlin, Plavix, Heparin, etc.) YES NO
Do you have a problem taking aspirin? YES NO

Do you have any known medication allergies? YES NO (if yes, please list)

_____________________ ______________________ ________________________
_____________________ ______________________ ________________________

Are you allergic to or have you ever had any adverse reaction to:
__ Shellfish __Adhesive __Latex ___None

SOCIAL HISTORY

Do you currently smoke? YES NO If YES, how many cigarettes do you smoke per day? ________________________
Have you ever smoked? YES NO If YES, what was approximate date you quit smoking? _______________________
Do you drink alcohol? YES NO If YES, do you drink daily, occasionally, or rarely? _________________________
How many drinks do you have? __________per day/per week (please circle which one).
Do you currently use any recreational drugs? YES NO
Are you claustrophobic? YES NO If yes: ___Severe claustrophobic ____Mild claustrophobic
Do you have any tattoos? YES NO Where located: ____

Please read and sign below. Thank you.

It is the responsibility of the patient to know his/her insurance requirements for referrals, precertification, network providers, and limitations of coverage. We will try to assist you in any way possible, but please understand there are numerous insurance plans and we are unable to know all details of each policy.
My signature below acknowledges that I am aware that I am ultimately responsible for charges whether covered or not by my insurance. I authorize any medical benefits to which I am entitled to be paid directly to Drs. Brahms Cohn & Leb Inc. I also authorize Drs. Brahms, Cohn, & Leb Inc. to release any and all information necessary to secure payment for charges incurred.

I hereby authorize this office through its appropriate personnel to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing and treating my/his/her physical condition.
I authorize this office to retrieve my/his/her medical history from SureScripts, an e-prescribing network.

Patient/Responsible Party Signature ____ Date _______________

DRS. BRAHMS, COHN & LEB INC.
23250 MERCANTILE ROAD
SUITE 100
BEACHWOOD, OHIO
44122
(216) 831-7855 - PHONE
(216) 831-5320 - FAX

PATIENT NAME______________________________________ DOB____________________ ACCT#__________________

General Medical Release

I hereby authorize Drs. Brahms Cohn & Leb Inc and its appropriate personnel to retrieve any medical records from my previous physicians and/or testing facilities that may be considered necessary for my care.

This includes but is not limited to:
__Any Cleveland Clinic Physician or Hospital
__Any University Hospital Physician or Hospital
__Only the doctors listed below:
____
____
____

Patient/Responsible Party Signature: ____ Date: _________________