

**STANLEY C GRAVES M.D.**

**2022**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH** / / \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **ALTERNATE:** \_\_\_\_\_

**PHYSICAL ADDRESS:** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**MAILING ADDRESS (IF DIFFERENT):** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**EMAIL** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**INSURANCE**

**PRIMARY INSURANCE:** \_\_\_\_\_ **SECONDARY INSURANCE** \_\_\_\_\_  
**(PLEASE PROVIDE COPIES OF BOTH CARDS FOR UPDATED INFORMATION)**

**INDUSTRIAL CASE:** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**ATTORNEY:** \_\_\_\_\_ **ATTORNEY PHONE NUMBER:** \_\_\_\_\_

**\*\*\*\*\*INSURANCE CONTRACT\*\*\*\*\***

**I UNDERSTAND I AM FULLY RESPONSIBLE FOR ANY CHARGES FROM AN OFFICE VISIT, INJECTION, OR SUPPLIES RECEIVED BY DR. STANLEY GRAVES THAT ARE NOT COVERED BY MY INSURANCE.**

\_\_\_\_\_ **RESPONSIBLE PARTY** \_\_\_\_\_ **DATE**

**I UNDERSTAND THAT IF MY ACCOUNT IS SENT TO ANY OUTSIDE COLLECTION AGENCY I WILL BE RESPONSIBLE FOR THE COLLECTION FEES (40%) AS WELL AS ANY ACCRUED INTEREST ON MY OUTSTANDING BALANCE.**

\_\_\_\_\_ **RESPONSIBLE PARTY** \_\_\_\_\_ **DATE**

**I UNDERSTAND AND ACKNOWLEDGE THE OFFICE NO SHOW POLICY. IF I MISS AN APPOINTMENT OR FAIL TO CANCEL AN APPOINTMENT 24 HOURS PRIOR TO THE SCHEDULED TIME I WILL BE HELD RESPONSIBLE FOR A NO SHOW FEE OF \$30.00**

\_\_\_\_\_ **RESPONSIBLE PARTY** \_\_\_\_\_ **DATE**

**PATIENT HISTORY FORM**

Stanley Graves, MD

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Current Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
Work Status: Full Time/ Part Time/ Restricted/ Disabled/ Retired/ Other: \_\_\_\_\_  
Left/ Right Hand Dominant?

Condition/Problem: Right / Left/ Bilateral

Date of Onset/ Injury: \_\_\_\_\_

How did the injury occur? \_\_\_\_\_  
Sports Injury/ Work Injury/ Auto Accident/ Other

Current Symptoms: \_\_\_\_\_

Describe how the injury occurred: \_\_\_\_\_

**Circle any that pain problems that apply:**

- |                |                |                 |
|----------------|----------------|-----------------|
| Aching         | Dislocation    | At Night        |
| Periodic       | Numbness       | After Activity  |
| Goes Elsewhere | Swelling       | During Activity |
| Shooting       | Popping        | When Resting    |
| Burning        | Paralysis      |                 |
| Electrical     | Weakness       |                 |
| Spasmodic      | Giving Away    | Other: _____    |
| Dull           | Soreness       | _____           |
| Sharp          | Nausea         | _____           |
| Throbbing      | Grinding       | _____           |
| Knife -Like    | Stiffness      |                 |
| Tingling       | Vomiting       |                 |
|                | Limited Motion |                 |
|                | Fever/Chills   |                 |
|                | Tenderness     |                 |

Previous Surgery: \_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous MRI/MRA: \_\_\_\_\_ X-Ray: \_\_\_\_\_ CT: \_\_\_\_\_

Circle all of the following diseases or medical problems that you have had:

- |                                |                                     |               |
|--------------------------------|-------------------------------------|---------------|
| High/ Low Blood Pressure       | Shortness of Breath                 | Eyes          |
| Anemia/ Transfusions           | Epilepsy/ Seizures/ Fainting spells | Low back pain |
| Radiation Treatments           | Heart Attack/ Heart Bypass Surgery  | Ears/ Nose    |
| Blood Clots/ Pulmonary Embolus | Pacemaker                           | Stomach       |
| Hepatitis                      | Heart Murmur/ Congenital Defect     | Drug Abuse    |
| HIV / AIDS                     | Mitral Valve Prolapse               | Alcohol Abuse |
| Hemophilia/ Abnormal Bleeding  | Bladder Problems / Kidney Problems  | Asthma        |
| Rheumatoid Arthritis           | Bowel Problems                      | Breathing     |
| Artificial Bone or Joints      | Diabetes                            | Psychiatric   |
| Bone Infections                | Polio                               | Gout          |

Medications: _____	Dose _____
_____	_____
_____	_____
_____	_____

Please List Any Allergies: _____	Reaction: _____
_____	_____
_____	_____
_____	_____

**Personal Information:**

Marital Status: Married/Single/Divorced/Separated/ Widow/ Other: \_\_\_\_\_

Children: Yes/ No How Many: \_\_\_\_\_

Do you live alone? Yes/ No

Do you exercise? Daily/ Weekly/ Rarely/ Never

Are you on a special diet? Yes/ No Explain:

History of substance abuse? Yes/ No Explain:

Do you currently smoke? Yes/No Explain:

Have you previously smoked? Yes/ No Explain:

Do you drink alcohol? Daily/ 1-2x's Per Week/ Never/ How much?

Patient Signature: \_\_\_\_\_

**Consent to Treat a Minor**

I Hereby Give My Consent for Treatment to: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Stanley C. Graves M.D., PC  
5080 N. 40<sup>TH</sup> ST., STE 103  
Phoenix, AZ 85018  
Phone: 602-952-8111  
Fax: 602-952-1572  
Email: [scg@stanleygravesmd.com](mailto:scg@stanleygravesmd.com)

**NON-CONTRACTED INSURANCE INFORMATION**

I have been notified that my physician, Stanley C. Graves M.D., PC, is not contracted with my insurance plan and that I am fully responsible for today's charges at the time of my visit. I also understand that Stanley C. Graves M.D., PC will refund to me any credit balance resulting from my insurance plan payment on charges that I have paid.

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Patient Name

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Acct #

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Patient or Responsible Party Signature

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Date

# HIPAA Compliance Patient Consent Form

**2022**

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

Under the HIPAA (Health Insurance Portability and Accountability Act of 1996) Law, you have the right to restrict how your protected health information is used and disclosed.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment or healthcare operations.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we discuss your medical treatment with any members of your family?    YES    NO

May we release your medical records to any members of your family?    YES    NO

May we speak with them regarding scheduling, confirming or changing appointments?    YES    NO

May we leave a message on their answering machine?    YES    NO

If YES, please name the members allowed:

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By signing this form, you consent to the use and disclosure of your protected health information to the following members:

This consent was signed by: \_\_\_\_\_

(PRINT NAME PLEASE)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PHARMACY INFORMATION  
Stanley Graves, MD

PATIENT NAME: \_\_\_\_\_

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

PHARMACY NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

CROSS STREETS: \_\_\_\_\_

DATE \_\_\_\_\_