

WELCOME

JOSEPH T. HAYES, M.D.

1970 North Broad Street

Lansdale, PA 19446

Telephone: (215) 669-2258

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

Last Name

First Name

Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

Name of Insurance Company(ies)

and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

Date

Relationship to Beneficiary

3 PHONE NUMBERS

Home (____) _____ Cell (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____

Work Phone (____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED
IN ANY OF YOUR BLOOD RELATIVES

Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis
 Heart disease Stroke High blood pressure Nervous illness Allergy Other

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HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes/Halos

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sore that won't heal

MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- AIDS Chicken Pox
- Appendicitis Diabetes
- Arthritis Emphysema
- Asthma Epilepsy
- Bleeding Disorders Glaucoma
- Breast Lump Heart Disease
- Cancer Hepatitis
- Cataracts Herpes
- Chemical Dependency High Cholesterol

- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses or operations _____

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MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

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HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine _____
- Street Drugs _____
- Tobacco _____
- Other _____

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

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SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date

Joseph T. Hayes, M.D., M.P.H.

1970 North Broad Street
Lansdale, PA 19446

Mercy Suburban Hospital
Medical Arts Pavilion
2705 DeKalb Pike, Suite 307
East Norriton, PA 19401

Phone: 610-633-6814 • Fax: 732-840-5374

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO THE INSURANCE CARRIER AND ASSIGNMENT
OF BENEFITS TO PHYSICIAN**

The office of Joseph T. Hayes M.D., P.C. has agreed to accept your insurance/health plan for payment of all services rendered unless specified otherwise. By signing below, you authorize this office to accept payments from your insurance company or health care plan. We further agree not to bill you for any balance that exceeds payment made by your insurance company or health care plan with the exception of all applicable co-pays, deductibles, and non-covered services. All applicable co-pays are due at the time services are rendered. **You may be charged for professional services rendered not covered under your plan at the time of service.**

NO SHOW FEES

Our practice is very unique because our average patient visit is 45 minutes long. Furthermore, for our patient's convenience, we attempt to keep your waiting time in our waiting room to a minimum; we have about a 90% record of getting our patients in on time. It is rare that a patient has to wait more than 10 or 15 minutes. To that end, we are very strict about our schedules. Thus, we ask for the patient's cooperation by being on time so they can get the maximum benefit of their visit. Also, no shows can be very disruptive, and they may deprive other patients of the opportunity for an appointment. In addition, no shows may cause an unnecessary wait for a new patient's first appointment. Therefore, we have set up the following No Show Fee Policy. We ask for a 3 day notice for cancellation of an appointment with no charge (calls must be received by 10 a.m.). Two day cancellations will result in a no show fee of \$50.00. A one day notice or a total no show will result in a \$100 no show fee. Thank you for your cooperation. All cancellations must be made to 610-633-6814.

RETURN CHECK FEE

Return checks will be charged at \$25.00 plus the outstanding balance.

I hereby agree to the terms above and authorize release of medical information necessary to file a claim with my health care plan or insurance company and assign benefits otherwise payable to Joseph T. Hayes, M.D.

Patient Signature _____

Patient/Print name _____

Date _____

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**HAYES PAIN MANAGEMENT
CONSENT AUTHORIZATION FOR TREATMENT**

I, _____, signed this form and requesting and consenting to the service offered by Joseph T. Hayes, M.D., which may include, but is not limited to medication administration, trigger point injections, nerve blocks, diagnostic tests, physical medicine, Trans Cutaneous Nerve Stimulation, acupuncture, Percutaneous Electric Nerve Stimulation, and psychological counseling to be performed by Joseph T. Hayes, M.D. and/or staff.

I hereby warrant that I have not been legally judged as incompetent. I understand that it is my right to determine the extent of my medical care, and that I may at the time refuse treatment and withdrawal my consent to the performance of any procedure and treatment.

I understand and have been informed that in the therapies described above, there are some risks to treatment. These risks include but are not limited to contusions, bruises, bleeding, and infections. I do not expect the clinician to be able to participate and explain all risks and complications, and I wish to rely on the clinician to exercise judgment during the course of treatment, to determine the best course of treatment which the clinician feels at the time based upon the facts then known is in my best interest. I recognize that no guarantees have been or can be made regarding the likelihood of success or of the outcome of any evaluation, treatment, procedure, or therapy performed by Joseph T. Hayes, M.D., and/or staff.

I hereby warrant that I have read and understand to my satisfaction all of the above.

Print Name Date

Patient's Signature Date