David K. Keith, D.O., LLC
Patient Registration

PATIENT INFORMATION:

Social Security # _____ - _____ - _____ E-mail Address _____

Patient Full Name _____ Sex ☐Male ☐Female

Home Address _____

City _____ State _____ Zip _____

Home Phone Number (_____) _____ May we call this #? Y N May we leave a message? Y N

Cellular Phone Number(_____) _____ May we call this #? Y N May we leave a message? Y N

Date of Birth _____ / _____ / _____ Marital Status: ☐Married ☐Single ☐ Divorced ☐ Widowed

Student? ☐ NO ☐ YES, where: _____ ☐Full-Time ☐Part-Time

Place of Employment _____ ☐Full-Time ☐Part-Time ☐ Retired

Work Phone Number (_____) _____ May we call this #? Y N May we leave a message? Y N

Referred Here By: _____

ARE YOU COVERED BY MEDICAL INSURANCE? ☐ **YES,** complete next section(s) **-or-** ☐ **NO,** I am Self-Pay

PRIMARY INSURANCE INFORMATION

DO YOU HAVE A COPAY? YES ☐ NO☐ AMOUNT $_____

Name of Insurance Company _____

Address of Insurance Company _____

City _____ State _____ Zip _____

Phone Number (_____) _____

Plan # _____ Group # _____

Name of Policy Holder _____

Relationship to Patient _____

Policy Holder's Social Security # _____ - _____ - _____

Policy Holder's Birthday _____ / _____ / _____

Policy Holder's Employer _____

SECONDARY INSURANCE INFORMATION

DO YOU HAVE A COPAY? YES ☐ NO☐ AMOUNT $_____

Name of Insurance Company _____

Address of Insurance Company _____

City _____ State _____ Zip _____

Phone Number (_____) _____

Plan # _____ Group # _____

Name of Policy Holder _____

Relationship to Patient _____

Policy Holder's Social Security # _____ - _____ - _____

Policy Holder's Birthday _____ / _____ / _____

Policy Holder's Employer _____

SEND STATEMENTS TO: Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ **PHONE** _____

RELATIONSHIP TO PATIENT: _____

IT IS IMPORTANT THAT ALL INFORMATION BE COMPLETE. ANY BLANK AREAS WILL CAUSE A DELAY IN PROCESSING YOUR CLAIM. PLEASE BRING YOUR INSURANCE CARD(S) AND THIS FORM TO THE RECEPTIONIST AFTER COMPLETION.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign below)

I hereby authorize David K. Keith, DO, LLC to furnish information to my insurance carrier concerning my illness and treatments and hereby assign the physician all payments for services rendered to myself or my dependents. I understand that I am financially responsible for any services rendered to myself or dependents regardless of any insurance claims.

MEDICARE PATIENTS

I understand that even though David K. Keith, DO, LLC accepts Medicare assignment for claims and reduces their fees accordingly, there are items that may be required in the course of my treatment that are not covered by Medicare and are my financial responsibility.

PATIENT SIGNATURE: _____ DATE: _____

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

David K. Keith D.O., LLC
28 Conservatory Drive Suite B
Barberton, Oh 44203
Phone: 330-861-4100 Fax: 330-861-0987

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- O Entire record
- O Immunization record
- O Most recent history and physical
- O Laboratory results from (date)_____ to (date)_____
- O X-ray and imaging reports from (date)_____ to (date)_____
- O Consultation reports from (doctor's names)_____
- O Medication list
- O List of allergies
- O Most recent discharge summary
- O Problem list
- O Other _____

4. I understand that the information in my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

- O Me, via my telephone answering machine or voice mail box at (_____) _____
- O My spouse _____
- O My family member _____
- O _____, the patient's non-custodial parent
- O Other _____ (relationship)_____.

For the purpose of effective communication of my condition and treatment plan.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____.

If I fail to specify an expiration date, event or condition this authorization will expire in 12 months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provider in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr David Keith.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
*If Signed by Legal Representative, Relationship to Patient Signature of Witness

Financial Policy

Dr. David Keith, LLC
Anna Dean Professional Park
28 Conservatory Drive, Suite B
Barberton, Ohio 44203

It is important to us that an understanding exists between the patients and our office regarding financial responsibility. Payment is ultimately the patient's responsibility. We accept cash, personal checks and credit cards (Master Card and Visa).

Regarding Health Care Insurance:
We will file insurance claims to your primary and secondary Insurance carrier as a courtesy. We will ask you to sign a release of information and an assignment of benefits. We can not accept responsibility for collecting your insurance benefits or enter into disputes over benefits. Unpaid balances are due at 45 days regardless of insurance delays.

Patients with Insurance:
Patients with health care insurance are required to pay their portion of the balance due on the date of service including deductibles, co-pays, co-insurance and non-allowed service. In the event an insurance company with which we do not participate refuses all or part of the fee, that unpaid portion will be billed to the patient. All accounts are due in full at 45 days regardless of insurance delays. We are willing to work with our patients experiencing difficulty meeting payment obligations.

Patients with Medicare:
We accept assignment and will file your claims to Medicare. Medicare will send payment directly to us. All Medicare patients will be expected to pay their 20% co-insurance, deductibles and non-allowed services on the day of service. As a courtesy, we will also file your secondary insurance.

Managed Care:
We have applied to participate in a number of HMO and PPO programs. Patients must pay their co-pays and deductibles on the day of service. If we are not yet on your plan's network, and your plan pays a lower amount of benefit when you see a provider not in your plan's network, we will accept the lower amount of benefit provided that you have paid your co-payment, the network co-insurance, and bring a copy of the explanation of benefit with your payment. An example is below:

Network Benefit:
Insurance company pays 80% of approved amount and patient pays 20% plus $10 co-payment.

Out of Network Benefit:
Insurance company pays 70% of approved amount after $10 co-payment and patient pays 30%

We will accept the 70%A of approved amount paid by insurance company and 20% plus
Co-payment as payment in full until we are listed in your network.
Most insurance companies will pay you directly; you need to bring your explanation of benefits
Into the office.

Workers' Compensation:
Patients must make a $50 deposit prior to the time of service. Your deposit will be refunded when Workers' Compensation pays. If denied the whole balance will be due.

Patients without Insurance:
Full payment is due on the day of service if you are not covered by health care insurance.

Minors and Divorce:
Adults accompanying minor patients are responsible for payment regardless of divorce decreed.

Thank you for understanding our Financial Policy and for helping us keep costs down.

I have read and understand the financial policy of this office.

Signature: _____ Date: _____

Family Information

Please list ALL household members:

Name: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____

Name: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____

Name: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____

Name: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____

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Name: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____

Name: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____

Assignment of Benefits:

II certify that the information on this form is correct and complete. I authorize Dr. David Keith, LLC to release any and all health care information in writing or verbally to the Health Care Financing Administration or my health insurance program(s) for it review and payment. I understand that some services may not be covered by my insurance program and that I am financially responsible for these services. I further understand that these charges could include amounts applied to my annual deductible, co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that routine exams or well care is not covered by Medicare or many other health insurance programs, and that I may be responsible for varying rules concerning hospitals, labs, and care.

___ Payment of all benefits due as a result to my treatment SHOULD be made directly to Dr. David Keith, LLC.

___ Payment of all benefits due as a result to my treatment SHOULD NOT be made directly to Dr. David Keith, LLC.

Consent To Release Medical Information

Patient: _____ **Birthdate:** _____

Physician releasing records:

Name: _____
Address: _____
_____
City: _____
Phone: _____
Fax: _____

Physician to receive records:

Name: Dr. David K. Keith, D.O., LLC
Address: Anna Dean Professional Park
28 Conservatory Dr. Ste B
City: Barberton, OH 44203
Phone: (330)861-4100
Fax: (330)861-0987

Reason for release: _____

Medical information to be sent:

___ Entire Medical Record, INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

___ Entire Medical Record, EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

___ Record of care from _____to _____INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

___ Record of care from _____to _____EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

___ If deemed necessary by Dr. _____, I authorize this information to be sent via FAX transmission.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective until _____, but that I may revoke my consent at any time by providing a written revocation of consent to the above named party.

_____ _____
Patient or Patient's Legal Guardian **Date**

_____ _____
Witness **Date**

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	_____		
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes				Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: (Include nonprescription) _____
_____
_____

Have you ever taken Phen-Fen/Redux? ..... no yes

Patient social history:

Marital status Single:_____ Married: _____ Separated: _____ Divorced:_____ Widowed:_____
Use of alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____
Use of tobacco: Never:_____ Previously, but quit:_____ Current packs / day: _____
Use of drugs: Never:_____ Type/Frequency: _____
Excessive exposure at home or work to: Fumes:_____ Dust:_____ Solvents:_____ Air-borne Particles:_____ Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

☐ Constitutional Symptoms
Good general health lately . . . . . No Yes
Recent weight change . . . . . No Yes
Fever . . . . . No Yes
Fatigue . . . . . No Yes
Headaches . . . . . No Yes

☐ Eyes
Eye disease or injury . . . . . No Yes
Wear glasses/contact lenses . . . . No Yes
Blurred or double vision . . . . . No Yes

☐ Ears/Nose/Mouth/Throat
Hearing loss or ringing . . . . . No Yes
Earaches or drainage . . . . . No Yes
Chronic sinus problem or rhinitis . No Yes
Nose bleeds . . . . . No Yes
Mouth sores . . . . . No Yes
Bleeding gums . . . . . No Yes
Bad breath or bad taste . . . . . No Yes
Sore throat or voice change . . . . No Yes
Swollen glands in neck . . . . . No Yes

☐ Cardiovascular
Heart trouble . . . . . No Yes
Chest pain or angina pectoris . . . No Yes
Palpitation . . . . . No Yes
Shortness of breath w/walking or lying flat . . . . . No Yes
Swelling of feet, ankles or hands No Yes

☐ Respiratory
Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? . . . No Yes
Spitting up blood . . . . . No Yes
Shortness of breath . . . . . No Yes
Wheezing . . . . . No Yes

☐ Gastrointestinal
Loss of appetite . . . . . No Yes
Change in bowel movements . . . No Yes
Nausea or vomiting . . . . . No Yes
Frequent diarrhea . . . . . No Yes
Painful bowel movements or constipation . . . . . No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain . . . . . No Yes

☐ Genitourinary
Frequent urination . . . . . No Yes
Burning or painful urination . . . No Yes
Blood in urine . . . . . No Yes
Change in force of strain when urinating . . . . . No Yes
Incontinence or dribbling . . . . . No Yes
Kidney stones . . . . . No Yes
Sexual difficulty . . . . . No Yes
Male - testicle pain . . . . . No Yes
Female - pain with periods . . . . No Yes
Female - irregular periods . . . . . No Yes
Female - vaginal discharge . . . . No Yes
Female - # of pregnancies . . . _____
Female - # of miscarriages . . . _____
Female - date of last pap smear _____

☐ Musculoskeletal
Joint pain . . . . . No Yes
Joint stiffness or swelling . . . . . No Yes
Weakness of muscles or joints . . No Yes
Muscle pain or cramps . . . . . No Yes
Back pain . . . . . No Yes
Cold extremities . . . . . No Yes
Difficulty in walking . . . . . No Yes

☐ Integumentary (skin, breast)
Rash or itching . . . . . No Yes
Change in skin color . . . . . No Yes
Change in hair or nails . . . . . No Yes
Varicose veins . . . . . No Yes
Breast pain . . . . . No Yes
Breast lump . . . . . No Yes
Breast discharge . . . . . No Yes

☐ Neurological
Frequent or recurring headaches No Yes
Light headed or dizzy . . . . . No Yes
Convulsions or seizures . . . . . No Yes
Numbness or tingling sensations No Yes
Tremors . . . . . No Yes
Paralysis . . . . . No Yes
Head injury . . . . . No Yes

☐ Psychiatric
Memory loss or confusion . . . . . No Ye
Nervousness . . . . . No Ye
Depression . . . . . No Ye
Insomnia . . . . . No Ye
Suicidal Thoughts . . . . . No Ye
Violent or Unusual Thoughts . . . No Ye

☐ Endocrine
Glandular or hormone problem . No Ye
Excessive thirst or urination . . . . No Ye
Heat or cold intolerance . . . . . No Ye
Skin becoming drier . . . . . No Ye
Change in hat or glove size . . . . No Ye

☐ Hematologic/Lymphatic
Slow to heal after cuts . . . . . No Ye
Bleeding or bruising tendency . . No Ye
Anemia . . . . . No Ye
Phlebitis . . . . . No Ye
Past transfusion . . . . . No Ye
Enlarged glands . . . . . No Ye

☐ Allergic/Immunologic
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics . . No Ye
Morphine, Demerol, or other narcotics . . . . . No Ye
Novocain or other anesthetics . No Ye
Aspirin or other pain remedies No Ye
Tetanus antitoxin or other serums . . . . . No Ye
Iodine, Merthiolate or other antiseptic . . . . . No Ye
Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrec information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. also authorize the healthcare staff to perform the necessary services I may need.

Signature of Parent or Guardian _____ Date _____

Doctor's Review

Signature of Doctor _____ Date _____