Dr. Peter E. Grays, M.D.

1909 Central Drive, Ste. 202
Bedford, TX 76021
817-571-4620

PHYSICIAN: ____________________ BEING SEEN TODAY

LOCATIONS: ____________ DATE: ____________

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: ____________ State: ____________ Driver's License # ____________

Name: ____________ LAST ____________ FIRST ____ MI ____ SEX __/__/__ DATE OF BIRTH (MM DD YY) ____ AGE   S M D W O MARITAL STATUS

Address: ____________ STREET (NO P.O. BOX's PLEASE) ____ APARTMENT ____ CITY ____ ST. ____ ZIP

Home Phone: (______) ____________ Email Address: ____________

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE)

Employer's Name: or School ____________

Employer's Address: ____________ STREET OR P.O. BOX ____ CITY ____ ST. ____ ZIP

Occupation: ____________ (____) ____________ WORK PHONE (____) EXT

Emergency Contact *(Please indicate a friend or relative not living at the same address.)* (____) ____________ PATIENT'S ALT. PHONE (Cell, Mobile, etc.) (____) EXT

____________ NAME ____________ PHONE ____________ RELATIONSHIP

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child______ Other: ____________ SPECIFY

Name: ____________ LAST ____________ FIRST ____ MI ____ SEX __/__/__ DATE OF BIRTH (MM DD YY) ____ AGE   S M D W O MARITAL STATUS

Address: ____________ STREET (NO P.O. BOX's PLEASE) ____ APARTMENT ____ CITY ____ ST. ____ ZIP

Home Phone: (______) ____________ Email Address: ____________

Full-Time Part-Time Retired Unemployed Student
EMPLOYMENT STATUS (PLEASE CIRCLE)

Employer's Name: or School ____________

Employer's Address: ____________ STREET OR P.O. BOX ____ CITY ____ ST. ____ ZIP

Occupation: ____________ (____) ____________ WORK PHONE (____) EXT

OTHER PATIENT INFORMATION

Spouse Name: ____________ Employer: ____________

Spouse's Work Phone: (____) ____________ (____) EXT Occupation: ____________

PRIMARY INSURANCE

Please provide copy of card to receptionist to attach to this form.

Insurance Company: ____________ Address: ____________ STREET OR P.O. BOX (____) ____ PHONE

Co-Pay Amount (if applicable): ____________ ____ CITY ____ ST. ____ ZIP

Primary Care Physician: ____________

Policy Holder: ____________ LAST ____________ FIRST ____ MI ____ SEX __/__/__ DATE OF BIRTH (MM DD YY) ____ SS#

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other ____________ (SPECIFY)

Employer's Name: ____________ ____ INSURED ID ____ GROUP NAME AND/OR NUMBER

Employer's Address: ____________ STREET ____ CITY ____ ST. ____ ZIP

SECONDARY INSURANCE

Please provide copy of card to receptionist to attach to this form.

Insurance Company:______________________ Address:______________________ (____)__________
STREET OR P.O. BOX PHONE

Co-Pay Amount (if applicable):______________________ __________ ____ ______
CITY ST. ZIP

Primary Care Physician:______________________

Policy Holder:______________________ ______________________ ____ ____ __/__/__ __________
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) SS#

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other ______________________
(SPECIFY)

Employer's Name:______________________ __________ ______________________
INSURED ID GROUP NAME AND/OR NUMBER

Employer's Address:______________________ __________ ____ ______
STREET CITY ST. ZIP

WORKERS' COMPENSATION

Workers' Compensation Insurance Name:______________________ Adj: __________

Address:__________ City__________ State_____ Zip______ Phone:__________

Claim #:______________________ DOI:______________________

What Employer: ______________________

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___ No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident__________ Have you reported the injury to your employer? ___Yes ___No When __________

Describe accident briefly: ______________________

Do you have an attorney representing you? ___Yes ___No Who is the attorney? ______________________

REFERRAL INFORMATION

Who referred you?______________________ Address:______________________ Phone: __________

Family Physician:______________________ Address:______________________ Phone: __________

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ:

Peter E. Grays, M.D., Surgical P.A. is committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that Peter E. Grays, M.D., Surgical P.A. has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to Peter E. Grays, M.D., Surgical P.A. all of my rights and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by Insurance Company, or any balance due after payments by my Insurance Company.

I appoint Peter C. Grays, M.D., Surgical P.A. to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial or payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

______________________ __________ ______________________ __________
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

HEALTH HISTORY

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)

Condition			Condition			Condition			Condition		
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			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			

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

______________________ ________ ______________________
______________________ ________ ______________________
______________________ ________ ______________________

Medications: (Include nonprescription) ______________________

Have you ever taken Fen-Phen/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			

ITEM 07-0567149/16786 COLWELL 1.800.637.1140

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**
- Chronic or frequent coughs.... 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 Yes
- Nervousness .... No Yes
- Depression .... No Yes
- Insomnia.................. No Yes

☐ **Endocrine**
- Glandular or hormone problem. No Yes
- Excessive thirst or urination .... No Yes
- Heat or cold intolerance ...... No Yes
- Skin becoming dryer......... No Yes
- Change in hat or glove size .... No Yes

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

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics . No Yes
- Morphine, Demerol, or other narcotics.......... No Yes
- Novocain or other anesthetics No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums .... No Yes
- Iodine, Merthiolate or other antiseptic .... No Yes
- 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 incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

________________________ ________________
Signature of Patient, Parent or Guardian Date

Doctor's Review

________________________ ________________
Signature of Doctor Date

Dr. Peter E. Grays, M.D., F.A.C.S.

Consent for Treatment

By signing this content, I am authorizing my physician (s) and /or another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the office of Dr. Peter E Grays, unless revoked by me in writing.

____

Patient or Legal Representative Signature   Date

Acknowledgement of Review of the Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Patient or Legal Representative Signature   Date

Please sign this page ONLY. Do not fill out the information, we will fill this out if records need to be released or are requested by our office.

Medical Records Release/Request Form

(Check One)
Release _____ Releasing information from us to you or your provider
Request _____ Requesting information from another provider to us

Date: ___________
Patient Name: ___________________________ DOB: _______________
Address: ____
Phone: ____________________ Social Security #: ____________________

I authorize Peter E. Grays, M.D. Surgical Center to release/request *(circle one)* the following:

Information Requested: ____
____
Purpose of Request: ____

To/From: *(Circle One)*
Name____
Address ____
Phone and Fax ____

- I understand that this authorization shall be valid at all times, but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.

Patient Signature: ______________________________Date: _________

Peter E. Grays, M.D., F.A.C.S.
GENERAL & LAPAROSCOPIC SURGERY
Diplomate of the American Board of Surgery

Bedford Office:
1909 Central Drive, Suite 202
Bedford, TX 76021
(817) 571-4620
Fax (817) 571-4701

www.surgery-grays.com
e-mail: drgrays@surgery-grays.com

Patient Financial/Office Policy

Thank you for choosing Dr. Peter E. Grays, M.D., Surgical PA for your healthcare needs. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date. If you request a copy, we will be happy to assist you with one.
BASIC POLICY: All co-payments are due prior to seeing the Doctor. Payments for services rendered are due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license), and credit cards. There is a $25 returned check fee due and payable from you for each check payment returned to us by your bank. **OUTSTANDING BALANCES:** Please note if there is an outstanding balance on your account, this is due and payable prior to seeing the doctor along with any necessary co-pays due that day. All accounts will need to be at a zero balance prior to your visit. If there is a misunderstanding a Patient Financial Counselor will be happy to assist you in this matter.
FOR PATIENTS WITH INSURANCE: As a service to our patients, we will bill your insurance carrier. We will also assist in billing your secondary insurance carrier, if applicable and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balances rests on you. Please understand insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you. It will be the patients' responsibility to provide the office with current insurance information. We will ask for your insurance card at your visit to obtain copy for our records. We may occasionally request a copy at a later date to update your records. Please always have your insurance card with you at each time of visit. It is your responsibility to notify our office PRIOR to being seen if any patient information has changed. (i.e. address, name, insurance information, etc.)
FOR PATIENTS WITH WORKER'S COMPENSATION: We gladly accept all injured workers. We will verify that your claim is open prior to being seen by the doctor. If your claim is denied or being disputed during the evaluation and treatment from the Doctor, please inform the office. We will only be able to evaluate and treat and treat the related work injury condition. All other issues will be billed to your private insurance, and you will be treated as if you are a patient with commercial insurance and all responsibility occurs. If surgery is needed, our office will obtain the necessary prior authorization from your Worker's Compensation Insurance, Surgery will not be performed without Prior Authorization. If you have any questions in this matter contact your Worker's Compensation Adjustor. In addition, if your claim has been denied, or if bills are un-paid after 60 days from the date of service the all fess will become your responsibility.
MEDICARE PATIENTS: We will bill Medicare for you. We will also bill your secondary insurance, if applicable. All co-payments, deductibles, and co-insurance are due and payable at the time service is rendered.

REFERRALS: If you have an HMO plan or your insurance company requires a referral authorization from your primary care physician. You will need to obtain this or contact our office with the information so we can help you obtain this needed information from your PCP or referring doctor for you.

SURGERY FEES: All co-payments, deductibles, and co-insurance are due by 5:00 P.M. the day prior to surgery. (We do take Credit Card payments over the phone) These fees will be provided for you and explained the day of scheduling. Surgery dates are subject to cancellation if deductibles and coinsurance fees are not collected prior to surgery. Our office will obtain any Prior Authorization your insurance company requires.

NON-COVERED CHARGES: Any charges not paid by your insurance company will require payment in full the time services are provided or upon notice of insurance claim denial.

CANCELLATION OF APPOINTMENTS: Our goal is to provide the highest quality of care to our patients and fairness to other patients and the doctor; we require at least 24 hours' notice when canceling your appointment. There is a $25 fee for missed appointments without 24-hour notification, which will be due and payable from you.

MEDICAL RECORDS: There will be a $25 fee for all copies of patient medical records, please allow 7-14 business days for copying.

FMLA/DISABILITY PAPERWORK: For every disability/FMLA paperwork filled out by our office there will be a $25 fee. This will not be done until paid. Please allow 2-3 business days for paperwork to be completed.

UN-PAID BALANCES: We ask that full payment be made at the time of service unless prior arrangements have been made through the billing office. If an insurance company has determined that a patient portion is due, the patient will receive a statement. If, after 90 days, the patient has failed to pay the balance full or has not made contact with the billing office, collection activity will ensue.

REFUNDS: Occasionally it is necessary to reimburse funds to patients. In this case, a refund will only be issued after the claim has reached its final adjudication with the insurance carrier. Refunds will be issued within 30 days once appeals and claims processing are complete. In order to be considered for a refund, a formal written refund request must be filed with the Billing Department.

CALLS TO DOCTOR: In order to provide the utmost in your surgical care it is not wise to practice medicine over the telephone, therefore if you have a question or urgency we will provide you with our next available appointment. If the doctor is not available or in surgery, we recommend the Emergency Room at Plaza Medical Center Downtown, or the nearest Emergency Room.

EMERGENCY VISITS AND AFTER HOUR VISTIS: If there is an emergency and you need to be seen and you do not have a visit, we will bill your insurance for the emergency care charge. What is un-paid is your responsibility.

MEDICATION REFILLS: Our policy is for the patient to call their pharmacy and ask them to fax the request to 817-571-4701. Requests are usually handled within one business day. Processing times may vary depending on the availability of your doctor, who for your safety must review each request prior to completion.

SURVEYS In becoming a patient of Dr. Peter E. Grays, you agree to not submit an online/written survey regarding Dr. Peter E. Grays without the written consent from our office.

BILLING CONCERNS: If you have any questions regarding your account, statement, or insurance information please contact our billing office at 817-571-4620 and ask to speak to our Billing Department.

MINORS: A parent or legal guardian must accompany patients who are minors. The accompanying adult (who consents to the treatment) is responsible for payment of the account.

I have read, understood and agree to the above Financial/Office policy for Dr. Peter E. Grays, MD Surgical Center.

____
Patients Signature

____
Date