MICHAEL B. HALLET, MD
PATIENT REGISTRATION INFORMATION

LAST NAME FIRST NAME MI TODAY'S DATE

STREET ADDRESS CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE # FAX NUMBER

DATE OF BIRTH SOCIAL SECURITY NUMBER M F GENDER M S D W MARITAL STATUS

PRIMARY INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD(S) TO A MEMBER OF OUR STAFF)

SELF SPOUSE CHILD

INSURANCE COMPANY NAME INSURED'S FULL NAME I NSURED'S BIRTHDATE RELATIONSHIP (CIRCLE ONE)

ID NUMBER, GROUP NUMBER AND/OR POLICY NUMBER

CLAIMS FILING ADDRESS STREET ADDRESS CITY STATE ZIP CODE

EMPLOYER NAME EMPLOYER ADDRESS CITY STATE ZIP CODE

SECONDARY INSURANCE INFORMATION (if applicable)

SELF SPOUSE CHILD

INSURANCE COMPANY INSURED'S FULL NAME INSURED'S BIRTHDATE RELATIONSHIP (CIRCLE ONE)

INSURED'S ID NUMBER, GROUP NUMBER AND/OR POLICY NUMBER

CLAIMS FILING ADDRESS CITY STATE ZIP

SPOUSE INFORMATION (IF YOU ARE A MINOR, PLEASE GIVE PARENT INFORMATION)

FULL NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

EMPLOYER NAME, EMPLOYER ADDRESSS EMPLOYER'S TELEPHONE NUMBER

OTHER INFORMATION

REFERRED TO OUR OFFICE BY? OTHER PHYSICIAN (S) ?

EMERGENCY CONTACT RELATIONSHIIP TELEPHONE NUMBER

INTERESTS &/OR HOBBIES

CURRENT MEDICATIONS

PHARMACY NAME AND TELEPHONE NUMBER HEIGHT WEIGHT LIST KNOWN ALLERGIES

I _____, HEREBY AUTHORIZE MICHAEL B. HALLET, M.D. TO PROVIDE MEDICAL CARE AND SERICES TO ME, MY SPOUSE OR MY DEPENDENT. I HEREBY ASSIGN MICHAEL B. HALLET, M.D. ANY AND ALL RIGHTS UNDER MY INSURANCE POLICY WITH _____
(INSURANCE CO.NAME)
AND I HEREBY DIRECT MY INSURANCE COMPANY TO PAY ANY AND ALL PROCEEDS PAYABLE UNDER THE TERMS OF THE PROVISION OF MY INSURANCE POLICY/CONTRACT.I ALSO CONSENT TO THE RELEASE OF ALL MEDICAL INFORMATION REQUIRED TO OBTAIN PAYMENT FROM THE ABOVE NAMED INSURANCE COMPANY. IN THE EVENT THAT THE ABOVE NAMED INSURANCE COMPANY DOES NOT PAY THE ENTIRE AMOUNT OF THE BILL OR STATEMENT RENDERED BY THE ABOVE NAMED PHYSICIAN FOR MEDICAL CARE SERVICES PROVIDED TO ME, MY SPOUSE OR MY DEPENDENT, I GUARANTEE AND PROMISE TO MAKE PAYMENT OF ANY AMOUNT, WHICH THE INSURANCE DOES NOT PAY. SHOULD COLLECTION ACTION BE NECESSARY, I AGREE TO BE RESPONSIBLE FOR COLLECTION PROCESSING FEES WHICH MAY BE ADDED TO MY ACCOUNT.

SIGNATURE TODAY'S DATE

MICHAEL B. HALLET,M.D.

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE_____/_____/_____ DATE OF LAST PHYSICAL EXAM_____/_____/_____

LAST NAME_____ FIRST NAME_____ MIDDLE_____

Social Security No. _____ DATE OF BIRTH_____/_____/_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

History of Present Illness

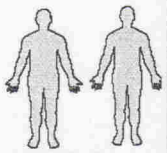
Please answer the following questions

Location of the problem

Front Back

Abdomen Back Leg

Other_____



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time?

YES **NO** If yes, please explain.

Nausea Rash Headaches

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does the problem interfere with your normal functions?

YES **NO** If yes, please explain_____

_____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

_____

_____

_____

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Are you on any medications? Y N (If yes, list all.)

_____ _____

_____ _____

Are you on a special diet? Y N (If yes, please explain)

_____

Do you have allergies? Y N (If yes, Please explain.)

_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

Pharmacia&Upjohn

(OVER)

USX 9787.00

8384-13

MICHAEL B. HALLET, M.D.

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other_____

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Allergic/Immunologic
- Hay Fever Y N
- Drug allergies Y N
- Other_____

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other_____

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other_____

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other_____

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Date: ____/____/____

Michael B. Hallet, M.D.
5969 E Broad St Suite 301
Columbus Ohio 43213

Privacy Consent – For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Michael B. Hallet, M.D. to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health cares professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Signature of Patient/Guardian_____

Date_____

Name printed_____

If not patient relationstionship_____

Patient unable to sign privacy statement due to:

_____

May we leave a message at your home with other residents? [ ] Yes [ ]No On your answering machine/voice mail? [ ]Yes [ ] No

May we contact you via mail, letter or postcard? [ ] Yes [ ] No

E-mail address _____ Can we communicate with you via the Internet? [] Yes [] No

Other Physician:_____ May we provide him/her with update information [] Yes [] No

Who may we talk to about your medical concerns _____

Relationship_____ Phone:_____