

Lake Physical Medicine Patient Registration

LAST NAME: _____ FIRST NAME: _____ MI: _____

PREVIOUS NAME: _____ DATE OF BIRTH (MM/DD/YYYY) _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ SEX: MALE / FEMALE EMAIL: _____

MARITAL STATUS: single _____ married _____ divorced _____ widowed _____ separated _____ PRIMARY CARE PHYSICIAN: _____

HOME PHONE: () _____ - _____ CELL PHONE: () _____ - _____

EMPLOYER: _____ RESPONSIBLE PARTY: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: () _____ - _____

MAY WE SHARE YOUR MEDICAL INFORMATION WITH ANYONE? **Y OR N**

IF YES, PLEASE INDICATE THEIR NAME: _____ AND THEIR RELATIONSHIP TO YOU: _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

WORK RELATED INJURY: Claim #: _____ DOI: _____ EMPLOYER: _____

WE WILL NOT RETROACTIVELY PURSUE WORKER'S COMPENSATION

Identification of other physicians involved with my medical care whom I authorize ongoing release of information for continuity of care.

PROVIDER: _____ PHONE: () _____ - _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

1. I authorize the release of all medical information to process claims for medical care received. I assign all medical benefits, including major medical benefits to which I am entitled to Lake Physical Medicine, this assignment to be considered as valid as the original.
2. I am aware of the Lake Physical Medicine (HIPAA) Privacy Act and I understand I may have a copy upon request.

PATIENT SIGNATURE: _____ DATE: _____

Lake Physical Medicine

DR. PATRICK BOYLAN • 9485 MENTOR AVE. 203 • MENTOR, OH 44060

Patient's Name: _____ Height: _____ Weight: _____

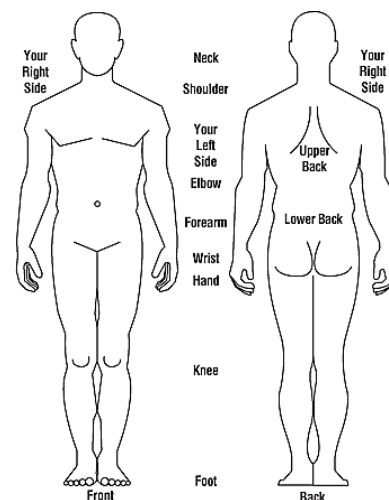
Reason for Visit: _____ Date the injury or symptoms began: _____

Primary Care Physician: _____

RATE YOUR PAIN

NO PAIN			MODERATE				WORST			
0	1	2	3	4	5	6	7	8	9	10

Use the body images to the right
to indicate the location of your
pain.



Medical History (please check all that apply)

- ☐ Unremarkable
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Esophageal Reflux
- ☐ GI Bleed
- ☐ Heart Attack
- ☐ HIV

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypo Thyroid
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Lupus
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Ulcer

☐ Vaccine History

☐ Flu (this year) ☐ Pneumonia (this year) ☐ Covid 19

Lake Physical Medicine

Please check if you are experiencing any of the following:

General

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Difficulty Sleeping
- ☐ Weight Gain
- ☐ Weight Loss

ENT

- ☐ Hoarseness
- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Ringing in the Ears

Respiratory

- ☐ Snoring
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath at rest
- ☐ Shortness of Breath with Exertion

Cardiovascular

- ☐ Leg Swelling
- ☐ Chest Pain
- ☐ Difficulty Laying Flat
- ☐ Irregular Heartbeat

Gastrointestinal

- ☐ Bowel Incontinence
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Throwing up Blood
- ☐ Nausea
- ☐ Vomiting

Eyes

- ☐ Double Vision
- ☐ Blurry Vision
- ☐ Dry Eyes

Hematology

- ☐ Easy Bruising
- ☐ Prolonged Bleeding
- ☐ Swollen Glands

Genitourinary

- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Incontinence

Musculoskeletal

- ☐ Joint Stiffness
- ☐ Painful Joints

Neurologic

- ☐ Balance Problems
- ☐ Difficulty Speaking
- ☐ Dizziness
- ☐ Headache
- ☐ Seizures
- ☐ Tremor
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling

Psychological

- ☐ Known Mental Health Disorder
(please list) _____
- ☐ Anxiety
- ☐ Substance Abuse

Surgical History – check all that apply

<input type="checkbox"/> Unremarkable <input type="checkbox"/> Abdominal Surgery <input type="checkbox"/> Amputation <input type="checkbox"/> Ankle Surgery <input type="checkbox"/> Appendectomy <input type="checkbox"/> Breast Surgery <input type="checkbox"/> Carotid Artery Surgery <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Cataract Surgery <input type="checkbox"/> Colon Surgery <input type="checkbox"/> Foot Surgery <input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Hand Surgery <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Hip Surgery <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Knee Surgery <input type="checkbox"/> Lung Surgery <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Surgery <input type="checkbox"/> Shoulder Surgery <input type="checkbox"/> Spine Surgery <input type="checkbox"/> Vascular Surgery <input type="checkbox"/> Other _____
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Family History

<input type="checkbox"/> Unknown	
<input type="checkbox"/> Unremarkable	
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Angina	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer type:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____

Social History

Alcohol Use	<input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
Recreational Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes
Smoke Tabaco	<input type="checkbox"/> Yes (how much _____) <input type="checkbox"/> No <input type="checkbox"/> Former
Do you live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow

Medication List

Allergies _____

Pharmacy _____

Blood Thinner _____ Prescribing Dr _____

Medication		Dosage	How often taken
	Example – Tylenol	325 mg	1 or 2 once daily
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Lake Physical Medicine

PATIENT PRESCRIPTION RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCES

1. I am responsible for the controlled substance medications prescribed to me. If any prescription is lost, misplaced or stolen or if I “run out early”, I understand that it will not be replaced.
2. **REFILLS ON CONTROLLED SUBSTANCE MEDICATIONS:**
 - a. Will be made only during regular office hours, in person once a month, during a scheduled office visit, or on the phone two days in advance. Refills will not be made at night, on weekends, or during holidays.
 - b. Prescription will not be filled if I “run out early”, lose a prescription, spill or misplace my medications. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
 - c. Will not be made as an “emergency” such as on Friday afternoon because I suddenly realized I will run out tomorrow. I will call 2-3 days prior to a refill.
3. I will not be rude to the office staff on the phone or in the office.
4. I agree to comply with random urine, blood or breathe testing, documenting the proper use of medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of state while taking the prescribed medications.
5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involved obtaining controlled substance medications from another individual or the use of non (illegal) prescribed drugs, I may be reported to all my physicians and the appropriate law enforcement authorities.
6. I understand that the main treatment goal is to reduce pain, improve my ability to function and work. In consideration of this goal, I agree to help myself by following better health habits, exercise, weight control and avoidance of the use of tobacco and alcohol.
7. I agree to only receive controlled substance medications while receiving pain management intervention from Dr. Patrick Boylan and not by any other medical professional. I understand that violation of these conditions will result in immediate removal from Oaktree Clinic as a patient and that I will have no recourse against Dr. Boylan. I am solely responsible for the procurement of any tapering doses required to avoid withdrawal when discharged from the practice.
8. I agree to provide Dr. Boylan with my pharmacy’s contact information at which I will fill all my prescriptions from Dr. Boylan. If I require changing pharmacies, I agree to notify Dr. Boylan.

PATIENTS SIGNATURE:_____

DATE:_____

Patrick T. Boylan MD Inc

Financial Policy

Date:_____

Patient Name:_____ D.O.B._____

- 1.) All co-pays are due at the time of service or you will not be able to see the physician.
- 2.) All balances are due at the time of service or arrangements can be made with our financial office before being seen by the physician.

Please remember that your co-pay and deductible is dictated by your insurance company and agreed to by you.

Patient Signature_____ Witness Signature_____