Allure
HEALTH & WELLNESS

New Patient Package

Thank you so much for choosing Allure Health and Wellness to be your new Primary Care Provider. At Allure Health and Wellness we offer numerous services such as Primary Care, Weight Loss, IV Hydration, Facials, Sports Physicals, and GYN visits. On your initial visit please make sure you bring the following items:

Form of Government ID with Picture
Insurance Cards
Medications you are currently taking

If you need to reschedule your appointment, we ask you to please give us 24 hours notice.

Please do not hesitate to call our office with any questions 410-505-7800.

We look forward to seeing you!

Allure HEALTH & WELLNESS

138 Coursevall Drive, Centreville, MD 21617
410-505-7800
allurehealthclinic@gmail.com

Please Print Clearly

Name (First, MI, and Last) : _____

NIckname: _____ Date of Birth:_____Sex:_____

Social Security Number:_____Marital Status:_____ Race:_____

Home Phone Number:_____ Cell Phone Number:_____

Email Address:_____

Physical Address:_____

City:_____ State:_____ Zip Code:_____

Mailing Address:_____

City:_____ State:_____ Zip Code

Medical History Form

Name:_____ Date of Birth:_____

Medication Allergies (List medications and give type of reaction)

1._____
2._____
3._____
4._____

List of Medications (Strength, Frequency, Provider...you may use another sheet of paper)

1._____
2._____
3._____
4._____

Vaccine History (List date administered and type of vaccination)

Influenza Vaccine:_____ Pneumonia Vaccine(s):_____

Tetanus Vaccine:_____Covid Vaccine:_____

Shingles Vaccine:_____

Specialists:

1._____
2._____
3._____
4._____

Eye Doctor:_____ Date of Last Visit:_____

Dentist:_____ Date of Last Visit:_____

Pharmacy:_____

Employer:_____

Emergency Contact:_____ Phone Number:_____

Insurance Information

Insurance Name:_____Member ID:_____

Group Number:_____Effective Date:_____

Billing Address:_____

Phone Number:_____Name of Insured:_____

Date of Birth:_____ Social Security Number:_____

Secondary Insurance:_____ Member ID:_____

Group Number:_____Effective Date:_____

By signing below, I represent that the information given by me to Allure Health and Wellness is accurate to the best of my knowledge)

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Patient/Responsible Party Print Date

Previous Medical Problems (Circle all that apply):

HIgh Blood Pressure Diabetes Asthma Cancer (specify type)_____
Heart Problems Breathing Problems Leaking Urine Swelling (specify site)_____
Palpitations Frequent Urination Gout Blood Disorder Pneumonia (when)_____
Thyroid Disease Kidney Stones Weight Problems Bowel Problems (type) _____
Kidney Disease Skin Problems HIgh Cholesterol Arthritis (Details) _____
Mood Issues (type)_____TB Exposure (details)_____
Other (Please specify)_____

Female Issues (type)_____
Age First Menstrual Period_____ Age Last Menstrual Period_____
Number of Pregnancies_____Number of Births_____
Date and Location of Last Mammogram_____
HIstory of Abnormal Pap (circle one) Yes/No History of Abnormal Mammogram Yes/No

Male Issues (type)_____
History of Elevated PSA (circle one) Yes/No HIstory of Enlarged Prostate (circle one) Yes/No

Previous Hospitalizations (problem, date or year)_____
_____
_____

Previous Surgical Procedures (details/dates)
Skin Procedures_____
Eye Procedures_____
ENT Procedures_____
Lung Procedures_____
Heart Procedures_____
Abdominal/Stomach Procedures_____
Urinary Procedures_____
GYN Procedures_____
Orthopedic Procedures_____
Colonoscopy/ Sigmoidoscopy (when & where)_____

Family HIstory (details, family member, age if known)
Cancer_____
HIgh Blood Pressure_____
Diabetes_____
Stroke_____
Heart Attack_____
Eye Problems_____
Bleeding Problems_____
Addiction/Substance Abuse_____

Mental Health Problems_____
Neurological Conditions_____
Other (please specify)_____

Social History: (Circle Yes or No for each question)

Seatbelt Use Yes/No
Regular Exercise Yes/No Type of Exercise_____
Bike Helmet Yes/No Guns in Home Yes/No Medical Advance Directive Yes/No
Tobacco/NIcotine Use Yes/No (Details)_____
Alcohol Use Yes/No (Details)_____
Drug Use Yes/No (Details)_____
Employment Status/Type of Work_____
Do you ever feel afraid in your home? Yes/No (details)_____
Method of Birth Control_____
Do you engage in activities that would place you in danger of contracting HIV/AIDS? Yes/No

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HEALTH & WELLNESS

Medical Release of Records

Patient Name:_____Date of Birth_____
Social Security Number_____

I hereby authorize:

_____

_____

_____

Phone Number_____Fax Number_____

To transfer my health care information to:

Allure Health and Wellness
138 Coursevall Drive
Centreville, MD 21617
Phone: 410-505-7800 Fax: 833-449-2022

The information obtained will be used in continuation of care.

Progress notes (last 2 office notes), most recent labs (including A!C), Immunization record, last wellness/physical exam, colonoscopy, mammogram, dexa scan

I understand that this authorization releases you from legal liability that may rise from disclosure of information requested.

_____ _____

Patient Signature Date

Allure
HEALTH & WELLNESS

Phone: 410-505-7800
Fax: 833-449-2022
allurehealthclinic@gmail.com

Authorization to Disclose Health Information
(Consent to Share)

Patient Name_____Date of Birth_____

I, _____ grant permission for the following person(s) to obtain information regarding medical care, and speak with the provider, and/or staff regarding the patient listed above.

Name	Relationship
_____	_____
_____	_____
_____	_____

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Patient/Responsible Party Print Date

Allure Health and Wellness

To our Patients Update to Notice of Privacy Practices for CRISP Participation

We have chosen to participate in the Chesapeake Regional Information System (CRISP) for our patients), a regional health information exchange serving Maryland, DC and the surrounding states.

As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information through CRISP by calling 877-952-7477 or completing and submitting an opt-out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substance Information, as a part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to Providers.

_____ _____

Patient Signature of Acknowledgement Date

_____

Patient Printed Name

HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

I, the undersigned, hereby authorize _____ ("Provider") to disclose certain information (described below) about me to **Allure Health and Wellness** for purposes of assisting Provider (or one of Provider's employees and agents).

I acknowledge and agree that my information may be used in **Allure Health and Wellness** training or website instruction or in connection with certification and renewal of certification examinations.

Provider is hereby authorized to disclose the following protected health information: my name, birth date, dates of services, treatment records that include treatment technique in your medical history, any unaltered x-rays used for diagnosis.

I understand that signing this Authorization is voluntary and that my treatment, payment, or eligibility for benefits will not be conditioned upon execution of this Authorization.

This Authorization shall expire one (1) year from the date of my signature, unless I revoke this Authorization sooner.

I understand that I may revoke this Authorization at any time by delivering a revocation in writing to the Provider. I understand that, if I revoke this Authorization, it will have no effect on actions already taken by Provider or **Allure Health and Wellness** in reliance on this Authorization.

I have read and understand the terms of this Authorization, and I agree to those terms.

_____ _____

Signature of Patient or Guardian, if applicable Date

_____ _____

Name of Guardian, if applicable Relationship of Guardian to Patient, if applicable

A signed copy of this Authorization must be provided to the patient and attached to the patient's medical record. A copy of this Authorization is as effective as the original.

PATIENT ACKNOWLEDGEMENT
APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical care to Allure Health and Wellness. When you schedule your appointment with Allure Health and Wellness we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule your appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment time. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/ No Show Policy below:

Effective June 1st, 2024

Any established patient who fails to show or cancels/reschedules and appointment and has not contacted out office with at least 24 hours notice will be considered a now show and charged a $25 fee.

Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice for a 2nd time will be charged a $50 fee.

If a third No Show or cancellation/rescheduled without a 24 hour notice should occur the patient may be discharged from Allure Health and Wellness.

The fee is charged to the patient not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, when time allows , we make reminder calls for appointments. If you do not receive a reminder call or message , the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office at 410-505-7800. If you do not receive an answer please leave a detailed message and someone will promptly return your call.

_____ _____

Patient Signature Date