OLNEY MEDICAL GROUP
PATIENT REGISTRATION FORM

Last name: _____ First name: _____MI:_____

DOB: _____/_____/_____ Sex: M☐, F ☐

Race: Asian ☐, Black ☐, Hispanic ☐, White ☐, Other:

_____

Marital Status: Single☐, Married☐, Divorced☐, Widowed ☐, Separated ☐

Street address:_____

City: _____State:_____Zipcode:_____

Cell Phone: (_____)_____ Home/Work Phone: (_____)_____

Email: _____ SSN:_____

Insurance name: _____ID:_____ NO Insurance ☐

Emergency Contact: _____ Relationship:_____

Cell Phone: (_____)_____ Home/Work Phone: (_____)_____

Preferred Pharmacy Name and Address :_____

Pharmacy Phone Number (_____) _____ Pharmacy Fax Number (_____)_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

A. I have read the notice of privacy practices and I have been provided an opportunity to receive it.

B. **Assignment of insurance benefits:** I hereby direct payment of surgical medical benefits to **OLNEY MEDICAL GROUP** for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

C. **Authorization to release information:** I hereby authorize **OLNEY MEDICAL GROUP** to release any medical care or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

D. **Medical record policy**: I hereby authorize **OLNEY MEDICAL GROUP** to release my medical record to: _____ Relationship: _____

E. **Insurance card and ID policy**: I understand that I must bring a physical insurance card and a current form of ID to every appointment. Without both physically present, I may be asked to reschedule my appointment. Picture of the insurance card or photo ID on your phone will not be accepted. Nor can we accept for copies to be emailed to the office, as that is a violation of HIPAA Regulations.

F. **Controlled pain medication/sleep medicine policy**: I understand that this office does **NOT** refill chronic pain and sleep medications. If needed, the office will give me a referral for pain management or psychiatrist.

Patient's Signature : _____ Date:_____

Ongoing medical problems: _____

_____

_____

Past medical/major history: _____

_____

_____

Past surgical history:_____

_____

_____

Medications (Indicate Strength and Directions):**

_____

_____

_____

Allergies (Indicate if MILD, MODERATE, or SEVERE)**:

Drug: No ☐, Yes ☐, If yes _____

Food: No ☐, Yes ☐, If yes _____

Environmental: No ☐, Yes ☐, If yes _____

Social history:

Tobacco use: Never ☐, Former ☐, 1-9 Cigs/Day ☐, 10-19 Cigs/Day ☐, 20-39 Cigs /Day or more ☐

Alcohol use: Never ☐, Former ☐, Monthly or less ☐, 2-4 Times/Month ☐, 2-3 Times/Week ☐, 4 or more/Week ☐

Family health history:

Diabetes: No ☐, Father ☐, Mother ☐, Sibling ☐, Other_____

Hypertension: No ☐, Father ☐, Mother ☐, Sibling ☐, Other_____

Heart problem: No ☐, Father ☐, Mother ☐, Sibling ☐, Other_____

Cancer: No ☐, Father ☐, Mother ☐, Sibling ☐, Other_____

Profession/Occupation:_____

Patient's Signature: _____ Date: _____

OLNEY MEDICAL GROUP
CAGE QUESTIONNAIRE

Last name: _____ First name: _____MI:_____

DOB: _____/_____/_____

1. Have you ever felt you should cut down on your drinking?

2. Have people annoyed you by criticizing your drinking?

3. Have you ever felt bad or guilty about your drinking?

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?

** Scoring:

Item responses are on the CAGE are scored 0 or 1, with a higher score an indication od alcohol problems. A total score of 2 or greater is considered clinically significant.

OLNEY MEDICAL GROUP
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Last name: _____ First name: _____MI:_____

DOB: _____/_____/_____

Over the last 2 weeks how often have you been bothered by any of the following problems?

Answer: 0 – Not at all
1 – Several Days
2 – More than Half
3 – Nearly Everyday

1. Little interest or pleasure in doing things 0
2. Feeling down, depressed or hopeless 0
3. Trouble falling asleep, staying asleep, or sleeping too much 0
4. Feeling tired or having little energy 0
5. Poor appetite or overeating 0
6. Feeling bad about yourself – or that you're a failure or have let yourself or family down 0
7. Trouble concentrating on things, such as reading the newspaper or watching television 0
8. Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual 0
9. Thoughts that you would be better off dead, or hurting yourself 0

Total: _____

10. If you checked off any problems, how difficult have those problems made it for you to: Do your work, take care of things at home, or get along with other people?

    Not Difficult at All: _____

    Somewhat Difficult: _____

    Very Difficult: _____

    Extremely Difficult: _____

OLNEY MEDICAL GROUP
IMMUNIZATION RECORDS

When did you last take?

VACCINE NAME	TAKEN (YES/NO)	NEEDS	GIVEN (DATE)
FLU SHOT		INTRADERMAL/ HIGH-DOSE	
TETANUS SHOT (Taken every 8-10 years)		Tdap or TD	
HEPATITIS B		NON-IMMUNE/ IMMUNE VERIFIED:	DOSE 1: DOSE 2: DOSE 3:
MMR		NON-IMMUNE/ IMMUNE VERIFIED:	
PNEUMONIA		PNEUMOVAX/ PREVNAR	
HEPATITIS A (Travel Vaccine)		NON-IMMUNE/ IMMUNE VERIFIED:	
TYPHOID SHOT		NON-IMMUNE/ IMMUNE VERIFIED:	
SHINGLES VACCINE		NON-IMMUNE/ IMMUNE VERIFIED:	

OLNEY MEDICAL GROUP

NEW PATIENT RECORD TRANSFER REQUEST

Date:_____
Physician's Name: _____
Address: _____
City: _____ State: _____ Zipcode:_____
Phone: _____ Fax: _____

I hereby request that my medical records be released to:

◯ **Gaurang Thaker, MD**

◯ **Leith Abdulla, MD**

◯ **Aneesa Keya, MD**

◯ **Amrutha Viswanatha, MD**

3411 Olandwood Ct Suite 105
Olney MD 20832
Tel. 301-774-5260 |Fax. 301-774-1336 | www.olneymedicalgroup.com

Patient's Name:_____
DOB _____ SSN_____
Address: _____
City: _____ State: _____ Zipcode: _____
Phone: _____ Email: _____

Patient's Signature: _____ Date:_____