Mid-Atlantic Internal Medicine

8021 Ritchie Highway Pasadena, MD 21122
Phone: 410-590-4617 Fax: 410-590-4618
www.midatlanticmedicine.com

Patient Information

Name:_____ Date of Birth: _____
Address:_____ Home Phone: _____
_____ Cell Phone: _____
E-mail: _____ Age: _____
Sex: Male Female Marital Status: _____
SS# _____ Occupation: _____

In case of Emergency, who should we contact? _____
Relationship to Patient_____ Phone number:_____

List of people who you authorize our physicians to discuss your medical conditions with:
Name/Relationship/Phone#
_____
_____

Which do you prefer to be your primary contact number? (Circle one) HOME CELL
Are we able to leave a message on your voicemail regarding medical results? YES NO
Are we able to mail medical results to your home address? YES NO
Local Pharmacy Name: _____ Location: _____
Mail Order Pharmacy Name (If applicable)? _____
May we download your medication history from your pharmacy? YES NO

Primary Insurance Company: _____
Policy Number: _____ Group Number: _____+
Policy Holder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____
Policy Number: _____ Group Number: _____
Policy Holder Name: _____ DOB: _____ Relationship: _____

Welcome to the Practice!

We briefly want to explain how we do things. Please request refills **at least** 2-3 days before you are out of medication. You will not hear back from us unless there is a problem with the request. We have a lab in the office for patient convenience but we do not own the lab. They are here M-F 8:30-5:00 but these times can vary. You can come in to have your labs drawn during these hours or immediately after your visit. If you have a test done here, you will hear from us even if the result was normal. If you do not hear from us after 2 weeks, please give us a call. We return all urgent messages the same day and non-urgent messages within 72 hours. Please do not call before 10 AM on the weekends unless it is an emergency. We really do appreciate your understanding.

~Dr. Sherry Sood and Staff

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Insurance and Payment Policy

We are committed to providing you with high quality medical care. We will facilitate the handling of your medical claims by completing insurance forms for you and accepting direct payment from your insurance carrier. In order to service your insurance needs, we require your understanding of our payment policy.

Please realize that:

1) We cannot guarantee that your insurance company will pay your claims. It is your responsibility to know your coverage based on your insurance plan**.** If your plan requires a referral from your primary, it is your responsibility to provide the referral or payment must be made at the time of the visit.
2) You are expected to provide complete and accurate information; this includes your full name, address, home telephone number, date of birth, social security number, email address, photo ID and your most up to date insurance card. Our staff is fully compliant with all the Health Information Portability and Accountability Act (HIPPA) regulations.
3) If you receive a monthly billing statement from our office, all outstanding balances are due within **30 days** of receiving your statement.
4) We require that you pay your co-pay at the time of your appointment.
5) We reserve the right to charge the guarantor a **$30.00** fee for missed appointments and **$50.00** fee for studies canceled with less than 24 hour notice. There will be a **$35.00** charge for all returned checks

Credit Card On File

All patients are required to keep a credit card on file for any outstanding deductible, co-pays or not covered amounts from your insurance carrier. Your credit card will be securely saved in our electronic health record system and no physical copy of your card information will be kept in the office for your protection. You will notified 5 days in advance (via email) for any charges that would be made from our office. If you would elect to pay these charges via another payment method simply call our billing department and we can make those arrangements immediately.

Initials _____

Patient Consent Form

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct healthcare operations such as quality assessments and physician certifications

I have the right to review the *Notice of Privacy Practices* documentation for a complete description of the uses and disclosures of my health information prior to signing this consent. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature:_____ Date:_____

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Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		EKG	
Tetanus Vaccine		Colonoscopy		Carotid Ultrasound	
Shingles Vaccine		Bone Density		Abd Aneurysm Screen	

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Highest Level of Education:
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)