4111 Lower Beckleysville Rd, Suite C

Hampstead, MD 21074

410-374-0808 410-374-0045 fax

Hampstead Primary Care wants to make your transition to our practice as easy as possible. The practice asks that you obtain the following information before a new patient appointment is made:

- Last two progress notes and/or last yearly physical progress note
- Most recent labs
- Medication list
- Immunization record
- Completed new patient packet

Who are you requesting to see in the practice: _____

Once the records are received with the completed new patient packet our providers will review them and then a staff member will call you to schedule an appointment. You may either drop the records off to the office or email the records to office@hampsteadpcp.com- **Please attach this cover sheet to your records.**

Please be advised that standard email communication is **not HIPAA compliant** and may not fully protect your privacy when sending sensitive information. If your message contains **Protected Health Information (PHI)**, we are unable to respond with detailed information via regular email due to privacy regulations. If PHI is included in your email, we will respond using a **HIPAA-compliant encrypted email system.**

Patient Name: _____

Date of Birth: _____

Phone number: _____

How were you referred to us? _____

************Staff use************

Date received: _____Reviewed by: _____

Provider notes:

Added to EMR on: _____Staff Name:_____

Appointment scheduled on: _____ Staff Name: _____

Patient Registration

Date_____

Hampstead Primary Care
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Hampstead, MD 21074
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_____ I prefer to be called:_____

First Name Middle Name Last Name

Address _____

City / State / Zipcode _____

Date of Birth_____Social Security # _____ Sex: □ Male □ Female

Home Phone _____Work Phone / Ext_____Cell Phone_____

Would you be interested in communication to you sent via email? If so, provide an email address.
Email Address_____

Emergency Contact Name_____Relationship:_____

Home # _____ Work # / Ext _____Cell #_____

Do you authorize this office to discuss your care, treatment or bills with any party besides yourself? □Yes □ No
Authorized Persons:_____

Can we leave personal information on any of the following: □ Home Phone □ Work Phone □ Cell Phone

Employer_____ Work Phone / Ext_____

Previous Medical Provider_____ Phone Number_____

Insurance Information

Primary Insurance Coverage

Insurance Company_____Phone #_____

Policy #_____Group#_____

Insurance Company Address_____

City / State / Zipcode_____

(Subscriber) Person that carries the Insurance_____

Subscriber Date of Birth_____Subscriber SS#_____Relationship to Patient_____

Secondary Insurance Coverage

Insurance Company_____Phone #_____

Policy #_____Group#_____

Insurance Company Address_____

City / State / Zipcode_____

(Subscriber) Person that carries the Insurance_____

Subscriber Date of Birth_____Subscriber SS#_____Relationship to Patient_____

PATIENT NAME_____**DATE OF BIRTH**_____

FINANCIAL POLICY

Stephen Laiken M.D., PA, dba/ HAMPSTEAD PRIMARY CARE is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy. For more details visit our website at: www.hampsteadpcp.com.

Insurances: We participate with several insurance companies. Please check with the office to see if we participate with yours. All patients will be responsible for presenting their insurance card at every visit and for completing registration updates semi-annually.

If we Do participate with your insurance company , all services performed in our office will be submitted to them unless we have received prior notification of non-covered services. All copays, co-insurances and deductibles are the patients responsibility. All patients are responsible for ALL copayments at the time of service. Deductibles and co-insurance will be billed to you by our office.

If you do not have insurance or an insurance card is not presented, all services performed will become the responsibility of the patient. Payment for services rendered in the office is due at the time of service.

Initial Visits to Establish Care: As part of your initial visit, your provider will perform a medical work-up that your insurance company may apply to your co-insurance/deductible.

This type of visit is designed to include a thorough review of your past medical history. It may include blood work or other testing, if indicated. Additionally, other complaints or issues may be addressed. Examples may include the management of diabetes/chronic diseases or the evaluation of a new complaint such as fatigue or joint pain.

In addition to the medical work-up, an annual physical exam may be performed. Since annual physical exams can only be billed yearly based on your insurance enrollment year, the provider may determine that you are currently not eligible for the service. Performing this service sooner than your insurance will allow, may cause your insurance to hold you responsible.

If the provider determines that you are eligible for your annual exam, they will include this additional service as part of the visit. This exam is for routine preventive care. The provider may review your overall health (including lifestyle risk factors, such as exercise and diet) and order any age-specific screening tests (such cancer screening or depression screening) and immunizations you may need. The goal is to identify risk factors or early signs and symptoms of chronic diseases, and counsel you on how you can reduce your risk and improve your overall health. Bloodwork may or may not be part of this visit, based on your individual state of health and your risk factors.

Preventive Care Visit: Your provider may order tests during your preventive care visit that may not be covered under your wellness benefit. These tests are covered under your medical benefits.

Additionally, at the time of the preventive care visit your provider may also treat an existing condition or illness. Tests and

Prescriptions: All prescriptions need 24 hours notice for the provider to process. Please call our office or your pharmacy at least 24 hrs before it is needed. There is a $25.00 charge for all controlled prescriptions that have to be written the same day.

Late Cancellation Fee: Our office requires 24 hour notice of cancellation. Patients will be charged a $65.00 fee for all appointments cancelled on the same day without justification. Automatic discharge from the practice after three same-day cancellations.

Late Arrivals: Arriving for a scheduled appointment 10 minutes late may require your appointment to be rescheduled and result in a missed appointment.

Missed Appointments: Patients will be charged a $65.00 fee for any missed appointment. Three missed appointments will result in automatic discharge from the office.

After Hours Charge: The on-call provider is available for urgent calls only. All non-urgent calls will be charged a $65.00 fee.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor.

Payment for services performed: Our office accepts VISA, MasterCard, Discover and American Express, cash or check. Each bounced check will be assessed a fee of $28.00. This fee is the responsibility of the patient and not the insurance company. For your convenience, payment can be made online thru a secure portal. All co payments are expected at the time of service. Payment in full of any past due balance is expected prior to being seen, unless prior arrangements have been made. Statement balances are due within 30 days of billing, unless prior arrangements have been made. All balances that reach 90 days may be sent to a collection agency. Balances sent to the collection agency will be reported to a credit reporting agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY HAMPSTEAD PRIMARY CARE AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient and/or Guardian (SEAL) Date

4111 Lower Beckleysville Rd, Ste C
Hampstead, MD 21074
410-374-0808 410-374-0045 fax

Multiple services may be performed on your initial visit to the practice. New patient visits to establish care are billed separately from your annual physical exam.

Establishing Care as a New Patient: This type of appointment is for your first visit with your new health care provider after switching your health care to our practice. It is designed to include a thorough review of your past medical history. It may include blood work or other testing, if indicated.

Not all new patients are eligible for an annual exam at the time of their initial visit to the practice. Since annual visits may only be billed yearly based on your insurance enrollment year, the provider may determine that you are currently not eligible for the service. If the provider determines that you are eligible for your annual exam, they will include this additional service as part of the visit.

The annual physical exam is performed yearly and is a time to provide routine preventive care. The provider may review your overall health (including lifestyle risk factors, such as exercise and diet) and order any age-specific screening tests (such cancer screening or depression screening) and immunizations you may need. The goal is to identify risk factors or early signs and symptoms of chronic diseases, and counsel you on how you can reduce your risk and improve your overall health. Bloodwork may or may not be part of this visit, based on your individual state of health and your risk factors.

To optimally address all your health concerns, other complaints or issues are best addressed during a problem visit. Examples include the management of diabetes or other chronic diseases or the evaluation of a new complaint such as fatigue or joint pain. *If these issues are addressed during your appointment for an annual physical, your health care provider may bill for these services in addition to your annual physical.*

Hampstead Primary Care
4111 Lower Beckleysville Rd
Hampstead, MD 21074

www.hampsteadpcp.com
email: office@hampsteadpcp.com
410-374-0808
compliance officer: Dr Stephen Laiken

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. 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 available through CRISP by calling 1-877-952-7477 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 Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

We will never share any substance abuse or mental health treatment records without your written permission.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of Notice: September 20,2018

Stephen Laiken, MD
email: office@hampsteadpcp.com
410-374-0808

Hampstead Primary Care

4111 Lower Beckleysville Rd
Hampstead, MD 21074
410-374-0808 . 410-374-0045 fax

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____
where am I requesting medical records from

Phone #: _____ Fax #: _____

to disclose the following information from the health record of:

Patient Name: _____ Phone #: _____

Address: _____ Date of Birth: _____

_____

Covering the period(s) of healthcare:
From (date) _____ To (date) _____

Information to be disclosed:

- ☐ Last History & Physical
- ☐ Last 3 Laboratory Tests
- ☐ Discharge Summary
- ☐ Last 3 Progress Notes
- ☐ Immunizations
- ☐ X-Rays
- ☐ Other (Please Specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ Infectious Disease
- ☐ Psychiatric Care
- ☐ Treatment for alcohol and/or drug abuse

This information is to be disclosed to:
Stephen Laiken, MD , Amy Yankolonis, CRNP, Susan Harris, CRNP and Amber Johnson, CRNP
for treatment and evaluation.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

The facility, it's employees, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the exent indicated and authorized herein.

If I have questions or change my mind, I know I can call.

Patient Signature: _____ Date: _____

Welcome to Hampstead Primary Care
New Patient Forms

Patient Name: _____ DOB: _____Date: _____

Please list **PROBLEMS** you would like evaluated today in order of significance:

1._____

2._____

3._____

Have you ever been diagnosed with? (select all that apply)

□ Asthma	□ Seasonal/ Food Allergies	□ High Blood Pressure	□ Heart Murmur
□ Cataracts	□ Glaucoma	□ Seizure/ Epilepsy	□ Lung Disease/COPD
□ Stroke	□ Heart Disease	□ Heart Attack	□ Liver Disease
□ Ulcers/ GERD	□ Digestive Disorder	□ Kidney Disease	□ Kidney Stone
□ Diabetes/Pre-Diabetes	□ Hypo/ Hyperthyroidism	□ Depression	□ Anxiety
□ Anemia	□ Bleeding Disorder	□ Bone/ Joint disease	□ Osteoporosis
□ High Cholesterol	□ Frequent Infections	□ Cancer (type)_____	□ Prostate Enlargement
□ HIV/ Hepatitis C	□ STD (type)_____	□ Mental Disorder _____	

□ Other_____

PAST MEDICAL HISTORY

Please describe and give dates of **surgeries**:

1._____

2._____

3._____

4._____

PLEASE LIST ANY SPECIALIST THAT YOU CURRENTLY SEE

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

IMMUNIZATIONS

Hepatitis B □ Yes □ No Date: _____ Hepatitis A □ Yes □ No Date: _____

Tetanus shot □ Yes □ No Date: _____Influenza (flu) □ Yes □ No Date: _____

Pneumonia Shot □ Yes □ No Date: _____Shingles Shot? □ Yes □ No Date: _____
Shingles Outbreak? □ Yes □ No Date: _____

Have you ever had a test for Tuberculosis? if yes (select): □ Positive □ Negative Date: _____

How was your Positive Tuberculosis diagnosed: Skin Prick/Blood Test/Chest X-ray?

Have you ever had a blood transfusion? if yes: Date(s): _____

Welcome to Hampstead Primary Care
New Patient Forms

Patient Name: _____ DOB: _____Date: _____

FAMILY HISTORY	Living/Deceased	Cause & Age of Death	Medical Conditions
MOTHER			
FATHER			
SISTER (S)			
BROTHER (S)			
DAUGHTER (S)			
SON (S)			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			

FAMILY HISTORY CONTINUED:

Is there any family history of?	Type or Age of onset	Relation to you
Cancer		
Heart Attack		
Stroke		
Mental Illness		

SOCIAL HISTORY

Marital Status: _____Your Occupation: _____

# of Children: _____ # Boys_____ # Girls_____# of People in Household: _____
Currently Live With: _____

Gender Identity □Male □Female □Female to Male □Male to Female

Sexual Orientation: □Lesbian/Gay □Straight □Bi-sexual □Don't know

Sexual Activity: □ Monogamous Relationship □ Not sexually active □ Multiple partners □ Does not practice "safe" sex

Are you an **ORGAN DONOR?** _____

List the amount **PER DAY** of beverages you regularly consume:

Coffee/Tea: _____ Beer: _____ Wine: _____ Hard liquor: _____ Soda: _____ Water: _____

I drink alcohol: □ Currently □ Occasionally □ Never □ Socially

Welcome to Hampstead Primary Care
New Patient Forms

Patient Name: _____ DOB: _____Date: _____

SOCIAL HISTORY CONTINUED

Smoking Status: □Never a smoker □ Current Smoker- How many packs per day: _____ Start Date: _____

□ Former Smoker - Smoking amount: _____ Start date: _____ Quit Date: _____ Any Smokers in home? □ Yes □ No

Have you ever used illicit drugs: □Yes □No If so, last date and which drug(s)?

_____

OTHER

Recent **Significant Changes** in Your Life? □Yes □No If yes, Explain_____

Financial Hardships? □Yes □No Have Special Stresses in Your Life? □Yes □No

I am **NOT** happy with (select those that apply) □Myself □My Health □My Work □My Partner □My Life

Do you feel safe in your current relationships? (family, friends, significant other) _____

Do you have a Living Will or Advanced Directive? _____

Do you exercise regularly? □Yes □No Type of exercise and frequency: _____

_____

Are you happy with your weight? □Yes □No How many meals/snacks do you eat per day? _____

How many meals do you eat out/carry out per week? _____

List any nutrition or diet concerns you would like help with: _____

If you are on a special diet? If yes, please explain:

_____

_____

Do you have regular Dental check-ups? □Yes □No How often do you brush/floss per day? _____

When was your last Eye exam? _____

Do you wear your seatbelt? □ Always □ Sometimes □ Never

Do you ride a motorcycle? □ Y □ N Bicycle? □ Y □ N Ski/Snowboard? □ Y □ N Skateboard? □ Y □ N

If yes, do you wear a helmet? □ Y □ N

Have you fallen in the last 6 months? If so, explain: _____

Have you been exposed to any Toxic Substances, such as asbestos, DES, radiation, chemicals? □ Yes □ No

If yes, please explain: _____

Do you have a smoke detector in the home: □ Y □ N When was it last checked? _____

Welcome to Hampstead Primary Care
New Patient Forms

Patient Name: _____ DOB: _____Date: _____

History Form

REVIEW OF SYSTEMS:
Select those items you **currently** have significant problems with.

GENERAL

□Recent Weight Change	□Increased Thirst or Urination	□Night Sweats/Hot Flashes
□Always Hot/Always Cold	□Rashes or Skin Problems	□Significant Fatigue

Do you have chronic pain problems? □Yes □No

BREASTS: Men & Women

□Lumps/Tenderness	Do You Do Monthly Self Breast Exams? □Y □N
□Drainage from nipples	Month and Year of Last Mammogram: _____

EYE, EAR, NOSE, AND THROAT

□Glaucoma	□Blurred or Double Vision- Ever	□Use Glasses or Contact Lenses
□Hearing Loss	□Brief Loss of Vision- Ever	□Use Dentures (Partial or Total)
□History of Radiation Therapy to Head or Neck		□Teeth or Gum Problems

CARDIOPULMONARY

□Shortness of Breath with Activity	□Dizziness	□Chest Pain
□Daily Sputum (Phlegm) Production	□Coughing Up Blood	□Heart Palpitations
□Difficulty Breathing While Lying Flat	□Leg Cramps While Walking	□Wheezing
□Waking Up Short of Breath	□Daily Cough	□Ankle Swelling

GASTROINTESTINAL

□Change of Appetite	□Abdominal Pain	□Blood in Stool/Black Stool
□Difficulty Swallowing	□Diarrhea/Constipation	□Frequent Nausea/Vomiting
□Heartburn	□Indigestion from Fatty Foods	

NEUROPSYCHIATRIC

□Frequent Disabling Headaches	□Difficulty Sleeping	□Tremors
□Frequent Anxiety or Anxiety Attacks	□Memory Loss	□Passing Out/Fainting
Treated in Past for Emotional or Psychological Problems: please describe _____		□Often Feel Sad or Depressed

MUSCULOSKELETAL & SKIN

□Frequent Neck or Back Pain	□Muscle Pain	□Disabling Night Leg Cramps
□Joint Problems	□Use a Brace or a Splint	

Mole that has changed color, size, shape, or won't heal? □Yes □No

GENITOURINARY: MEN & WOMEN

□Urinary Tract Infections	□Sores in the Genital Area
□Difficult or Painful Urination	□Blood in Urine
□History of Kidney or Bladder Stones	□Urination More Than Once a Night
□History of Four or More Sex Partners	□Sexual Intercourse Before 18 years old
Method of Birth Control: _____	

Have you ever had any Sexually Transmitted Disease: □Yes □ No
if yes, please describe: _____

GENITOURINARY: MEN ONLY

Pain or Lump in Testicles/Scrotum □Yes □No	Do you do Self Testicular Exam: □Yes □No Have you had a PSA: □Yes □No

GENITOURINARY: WOMEN ONLY

Age of first Period: _____	Frequency/Length of Menstrual Periods: _____
Date of Last Menstrual Period: _____	Change in Menstrual Pattern □Y □N
Number of Pregnancies: _____	Number of Children: _____
Disabling Menstrual Cramps □Y □N	Unusual Vaginal Discharge/Itching □Y □N
Date of Last Pap Smear: _____	Date of last Mammogram_____
History of Abnormal Pap Smear: □Y □N	Any Treatments for Abnormal Pap: _____

Provider Comments

Patient Name: _____ DOB: _____Date: _____

Medication List

Preferred Pharmacy: _____Phone: _____
Pharmacy Address: _____

MEDICATION ALLERGIES: (such as penicillin) _____
What happens when you take that medication? _____

OTHER ALLERGIES: (such as bees, foods, latex, etc.) _____
What happens when you are exposed? _____

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		