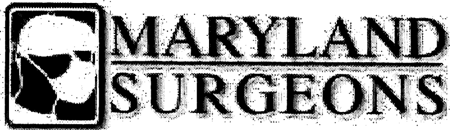

Date____________________

Name ________________________________ Social Security # __________________

Address _______________________________ Date of Birth ____________________

City ________________ State _____ Zip ______ Sex ______ Marital Status ________

Home Phone # _____________ Work Phone # _____________ Cell# ________________

Employer ________________ Preferred language:___________Race: _________________

Email address: ____

Pharmacy: _________________City: _____________Pharmacy Phone #:_______________

Person to Notify in an Emergency ____

Relationship _______________ Phone Number ____________________________

Primary Care Physician ______________________ Referring Physician _______________

Insurance Information:

Primary Insurance _________________________

Are you the policyholder? _____Yes ____No

If not, policyholder's name? ____________________

Policyholder Date of Birth ____________________

(*this information is NOT on the card*)

Relationship to Patient _____________

Policyholder Employer _____________

Secondary Insurance _______________________

Are you the policyholder? _____Yes ____No

If not, policyholder's name? ____________________

Policyholder Date of Birth ____________________

Relationship to Patient ______________

Policyholder Employer _____________

Other Health Care Providers

GYN Name________________________Phone ______________Fax__________

Gastroenterologist ____________________Phone______________Fax___________

Oncologist __________________________Phone______________Fax___________

Date__________________

ASSIGNMENT AND RELEASE:
**I hereby assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the physician to release any medical information required to process this claim.
I authorize my provider's office to contact me by telephone to remind me of my appointments.
I authorize Saint Agnes Health to download my current medications for purposes of insurance payment.
I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities
I hereby consent to treatment by my Saint Agnes Health provider(s). I authorize Saint Agnes Health to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general healthcare operations, which may include use of an electronic health information exchange**

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.
I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occured prior to the date of the revocation will not be affected.

By signing this consent, I authorize **St. Agnes HealthCare** and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name:___________________ Relationship:_______________

Method of Communication:________________________________

Name:___________________ Relationship:_______________

Method of Communication:________________________________

May we contact you regarding your protected health information, health status, appointments, and test results?

_Yes, you may contact me by e-mail; my address is:________________

_No, do not contact me by email for this purpose.

_Yes, you may contact me by phone; my daytime phone numbers are:
(   )_______-______ (   )_______-________

_Yes, you may contact me at the following fax number (   )_____-______
May we leave a message regarding your protected health information at the numbers you provided above?
__Yes __No

Signed____ **Date:**______________________

Date________________

Name: ______________________________ Primary Care Physician:____________

Date of Birth: ____________ Age: _____ Referring Physician: ________________________

1. Reason for visit: ______________________________Work related?__________________

2. Do you have allergies to medications? ☐ No ☐ Yes
List medication & reaction (i.e. rash, trouble breathing)
____

3. Any allergy to: ☐ latex; ☐ tape; ☐ betadine scrub; ☐ contrast (IV dye)? (check item if allergic)

4. Current medications (include dosage):

____

____

____

5. Past or present medical problems: (check all that apply)

- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic cough
- ☐ Chronic lung disease
- ☐ Cirrhosis of the Liver
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ DVT
- ☐ Emphysema
- ☐ Frequent UTI/ Kidney Infection
- ☐ Heart Attack
- ☐ Heart murmur/ Rhuematic Fever
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ Irregular heart beat
- ☐ Irritable bowel syndrome
- ☐ Kidney disease/failure
- ☐ Multiple Sclerosis
- ☐ Ovarian cyst
- ☐ Pancreatitis
- ☐ Parkinson's disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Seizures
- ☐ Skin cancer
- ☐ Stomach/ duodenal ulcer
- ☐ Stroke or paralysis
- ☐ Thyroid disease
- ☐ Transfusions
- ☐ Ulcerative colitis

6. Past surgeries:

☐ NONE ☐ Appendectomy ☐ Gallbladder ☐ Hernia Repair ☐ Colon Resection ☐ Other: ____________

7. Have you or any family member ever had a problem with anesthesia? ☐ No ☐ Yes

8. Family history:

	Father	Mother	Brother	Sister
a) Heart Trouble:	☐	☐	☐	☐
b) Cancer:	☐	☐	☐	☐
c) Diabetes:	☐	☐	☐	☐

9. Social history:

a) Tobacco use: ☐ never smoked ☐ smoker: how much________ ☐ ex-smoker: quit when _____

b) Alcohol use: ☐ none ☐ rarely ☐ often ☐ daily

c) Occupation: ____________________________

MARYLAND SURGEONS

Date___________________

Patient Name: ______________________________ Date Of Birth: _______________

REVIEW OF SYSTEMS

Please circle any illness or problems that you are currently experiencing.

GENERAL	☐ NONE	Weight gain, Weight loss, other__________
EYES	☐ NONE	Change in vision, poor vision, other__________
EAR/NOSE/THROAT	☐ NONE	Sleep apnea, hearing loss, other:__________
RESPIRATORY	☐ NONE	Shortness of breath, wheezing, other:__________
CARDIOVASCULAR	☐ NONE	Chest pain with activity, pain in legs with walking, **Date of last** EKG__________, Stress Test__________, Echo__________, and/or Cardiac Cath: __________
GASTROINTESTINAL	☐ NONE	Blood in stool, yellow eyes/ skin, other:__________
GENITOURINARY	☐ NONE	Difficulty urinating, kidney stones, other:__________
MUSCULOSKELETAL	☐ NONE	Severe back pain, severe joint pain, other:__________
SKIN	☐ NONE	Rash, MRSA, other:________
NEUROLOGICAL	☐ NONE	Severe headaches, pain/numbness in legs, other:__________
PSYCHIATRIC	☐ NONE	Depression, anxiety, other:__________
HEMATOLOGIC	☐ NONE	Blood clots, transfusions, other:__________
ENDOCRINE	☐ NONE	High blood sugar, excessive thirst, other:__________