Patients Name: _____

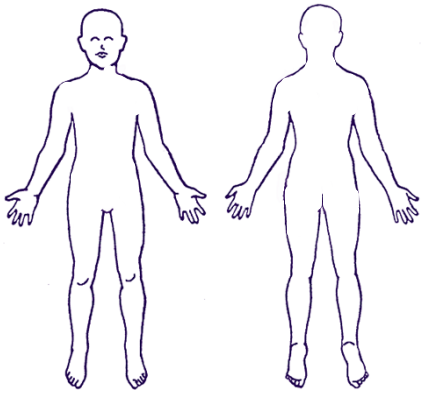
Patient Medical History Form

Describe briefly your present symptoms:

_____

_____

Please circle all the locations of your pain:



Surgeries: Type Year

_____

_____

_____

Hospitalization: Reason Year

_____

_____

_____

Previous treatment for this problem: (Check all that apply)
-Physical Therapy _____ -Steroid Injections_____
-Surgery _____ -Aquatic Therapy_____

Past medical history (Please include all previous diagnosis):

_____

_____

SOCIAL HISTORY:
Do you: (Check all that apply)

Smoke____ **Former Smoker** _____ When did you quit? _____

Drink alcohol _____ How **often**: Occasionally____ 1-2 times a week _____ Daily____ Other_____
Exercise Regularly _____ **Have tattoos** _____ **Sexually Active:** _____
Have Children_____ If yes, how many: Sons_____ Daughters_____
Travel outside the USA _____ Please list most recent (Last 10 years, include year)

_____
Blood Transfusion _____ If yes, what year? _____
HIV Tested _____ Positive/Negative? (Circle One) What year were you last tested? _____
Been diagnosed with an STI _____ If yes, please list:

_____
Recreational drug use____ Yes ___ No ___ If yes, please list:

_____
Marital Status:
Married ____ Single ____ Divorced ____ Widowed ____ Separated ____
Employment: Currently employed____ Occupation? _____
Disability____ Unemployed ____ Receiving unemployment ____ Other _____

Pharmacy: Name_____ Address_____ Phone Number_____

Primary Care Physician: Name_____ Phone Number_____

Referring Physician: Name_____ Phone Number_____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.):

Drug Name **Strength** **Frequency**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Drug allergies: Yes ___ No ___ (If yes please list the medication and type of reaction)

_____

_____

FAMILY HISTORY: Please check all that applies, and if family member is alive or deceased.

	Diabetes	Hyper-tension	Heart Disease	Stroke	Mental Illness	Cancer	Rheum Arthritis	Arthritis	Lupus	Gout
Father Alive_ Deceased_										
Mother Alive_ Deceased_										
Maternal Aunt Alive_ Deceased_										
Maternal Uncle Alive_ Deceased_										
Paternal Aunt Alive_ Deceased_										
Paternal Uncle Alive_ Deceased_										
Paternal Grandfather Alive_ Deceased_										
Paternal Grandmother Alive_ Deceased_										
Maternal Grandfather Alive_ Deceased_										
Maternal Grandmother Alive_ Deceased_										
Siblings										
Children										

Office Policies

Effective June 19, 2025
We are committed to providing safe, efficient, and transparent care. Please review our updated office policies:

---

1. Lab & Procedure Results

A. Abnormal results: You will be contacted by phone.
B. Normal results: Reviewed at your next scheduled visit.
C. Please allow 3–5 business days for results.

---

2. Prescription Refills

A. Routine refills can be called in or faxed to your pharmacy; allow up to 72 hours.
B. Refill requests should be made at least 5 days before running out.
C. Some meds require prior authorization—this may take several days.
D. Controlled substances must be electronically sent to your pharmacy.
E. Refill faxes: 410-744-8036

---

3. Labs & Imaging Before Appointments

A. Complete all tests ordered at least 5 days before your next visit to ensure timely review.

---

4. Cancellations / No-Shows

A. Less than 24-hour notice or missed appointments: $75 fee (not insurance-covered).
B. No-show fees must be paid before your next visit.
C. Repeated no-shows may lead to dismissal.
D. Weather-related cancellations are exempt—check our Facebook page or call us.

---

5. Insurance Verification

A. We verify insurance before each visit and provide info on your coverage, copay, and deductible.

---

6. Deductibles & Financial Responsibility

A. Payment is due at time of service if a deductible remains:
   • $650 for new patients
   • $300 for return visits
   • Or your remaining deductible—whichever is less.
B. HSA/HRA plan holders may be exempt.
C. You may still receive a bill for remaining balances after insurance processing.

---

7. Copayments

A. Copays are required at check-in.
B. Accepted payments: credit/debit, HSA cards, or cash.

---

8. Referrals

A. If your plan requires a referral, you must obtain it prior to your visit.
B. Without a valid referral:
   • You may be rescheduled, or
   • You may be responsible for full cost.
C. Bring your insurance card and photo ID to all appointments.

9. Medications & Durable Medical Equipment (DME)

A. Insurance benefits are verified before supplying injectable meds or braces.

B. If required, meds may be sent to your pharmacy. Otherwise, they are dispensed and billed through our office.

C. Braces are dispensed in-office unless your plan specifies otherwise.

---

10. Billing & Payments

A. Claims are submitted to your insurance after each visit.

B. Any remaining balance is billed to you—due within 30 days.

C. Unpaid accounts after 90 days may be sent to collections per Maryland law.

D. Returned checks: $25 fee

---

11. After-Hours & Weekend Calls

A. Non-urgent calls or refill requests after hours may incur a $50 fee.

B. Emergencies: Call 911 or go to the nearest ER.

---

12. Inclement Weather

A. Your safety is our priority.

B. Weather-related cancellations will not be penalized.

C. Check Facebook or call for closure updates.

---

13. Privacy & HIPAA

A. We follow all HIPAA regulations.

B. Please update us if your address, phone, or communication preferences change.

---

14. Patient Choice of Provider & Pharmacy

A. You have the right to choose your provider and where to fill prescriptions. This includes our new in-office pharmacy, available for your convenience. If your current pharmacy is no longer ideal, speak with your provider about the options.

B. Your rights under Medicare, Medicaid, Tricare, and commercial plans include:

C. Freedom to Choose any licensed pharmacy.

D. Transparency around medication costs and delivery options.

E. We offer our in-office dispensary to make your treatment more convenient—but the choice is always yours.

I _____, have read and acknowledge receipt of the policies listed above.

Signature: _____

Consent and Assignment- Please read before signing

MEDICARE: I authorize any holder of medical or other information about me to be released to the Social Security Administration and or its intermediaries or carriers with any information needed for this or related Medicare claim Title (XVII). I permit a copy of this authorization to be used in place of the original and request payment of Medical insurance benefits either to myself or the party who accepts the assignment below. I understand that I am responsible for any health insurance deductible, co-insurance (co-pay), and non-covered charges.

BLUE SHIELD OF MARYLAND: I understand the charges of a non-participating physician may exceed the Blue Shield of Maryland, Inc payment and, if greater, I will be responsible for that amount. I authorize the release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductible, co-insurance (co-pay), and non-covered charges.

LEGAL ASSIGNMENT (applicable to Physician Services): The undersigned expressly agrees if, upon default, this matter is referred for collection, the undersigned agrees to pay for attorney fees of (15%) of the outstanding balance at the time of referral, which percentage and the amount of resulting therefore are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

WORKMAN'S COMPENSATION: I understand that if for any reason my worker's compensation carrier denies payment for services that were rendered to myself, I will be financially responsible.

AUTOMOBILE INSURANCE: I understand that once my PIP has been exhausted, I will be financially responsible for any charges incurred in the event our office does not accept my health insurance and services that are not authorized by my health insurance.

INSURANCE- I authorize and assign payment directly to the physician involved in my treatment and authorize the release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

MANAGED CARE: I understand that without an authorization/referral from my HMO/PPO/PPA/POS plan, I will be financially responsible for charges incurred from our clinic.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN:

Signature: _____ Date: _____

Relationship to patient: _____

Patient Demographics

Name: _____ DOB: ___/___/___

Last First M.I.

Home Address: _____ Email: _____

Street Apt # City State Zip

Best Contact Phone Number: _____ Secondary Phone Number: _____

Emergency Contact: Name_____Relationship:_____

Contact Phone Number: _____