Patient Registration

Frederick Health Medical Group

Patient Information

PATIENT NAME (First, Middle, Last) **DATE OF BIRTH** **PRIMARY CARE PROVIDER**

STREET OR MAILING ADDRESS (P.O. Box) **CITY** **STATE** **ZIP CODE**

HOME PHONE **CELL PHONE** **WORK PHONE** **EMAIL ADDRESS** (Required for Patient Portal)

PRIMARY LANGUAGE

PREFERRED CONTACT METHOD (Check all that apply): ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Home Address (Letter) ☐ Portal

EMPLOYER

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Active Military ☐ Homemaker ☐ Unknown

STUDENT STATUS: ☐ Full Time ☐ Part Time ☐ Not a Student

EMERGENCY CONTACT NAME **RELATIONSHIP TO PATIENT** **PHONE** DAYTIME EVENING

BIRTH SEX
- ☐ Female
- ☐ Male
- ☐ Undifferentiated

LEGAL SEX
- ☐ Female
- ☐ Male
- ☐ Unknown/Undifferentiated
- ☐ Non-binary
- ☐ Other

SEXUAL ORIENTATION
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, or homosexual
- ☐ Something else (please describe): _____

MARITAL STATUS
- ☐ Annulled
- ☐ Choose not to disclose
- ☐ Divorced
- ☐ Legally Separated
- ☐ Life Partner
- ☐ Married
- ☐ Married, Common Law
- ☐ Single
- ☐ Unknown
- ☐ Widowed

PRONOUN
- ☐ Choose not to disclose
- ☐ He, Him, His
- ☐ She, Her, Hers
- ☐ They, Them, Theirs
- ☐ Ze, Hir

GENDER IDENTITY
- ☐ Choose not to disclose
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify): _____

RACE
- ☐ American Indian/Alaskan Native
- ☐ Decline to Answer
- ☐ White/Caucasian
- ☐ Asian
- ☐ Native Hawaiian/ Pacific Islander
- ☐ Black/African American
- ☐ Unknown/Unable to Answer
- ☐ Other: _____

ETHNICITY
- ☐ Cuban
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ Decline to answer
- ☐ Mexican or Chicano
- ☐ Other Hispanic Origin
- ☐ Unknown/Unable to answer

Organ Donor: ☐ **Yes** ☐ **No**

Interpreter needed? ☐ **Yes** ☐ **No**

Veteran Status: _____

Responsible Party/Guarantor

RESPONSIBLE PARTY NAME (First, Middle, Last) **DATE OF BIRTH** **EMPLOYER**

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Guardian ☐ Self ☐ Spouse ☐ Other: _____

ADDRESS **HOME PHONE** **WORK PHONE**

SEX: ☐ Female ☐ Male ☐ Undifferentiated

CONTINUED ON REVERSE

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID# **GROUP#**

SUBSCRIBER NAME (Policy Holder) **DATE OF BIRTH**

ADDRESS **PHONE**

RELATIONSHIP TO PATIENT:

- ☐ Child
- ☐ Dependent
- ☐ Domestic Partner
- ☐ Donor Insured by Rec Patient
- ☐ Father
- ☐ Guardianship
- ☐ Mother
- ☐ Organ Donor Insured by Patient
- ☐ Parent
- ☐ Same as patient
- ☐ Self
- ☐ Sponsored Dependent
- ☐ Spouse
- ☐ Subscriber Covers Injured Plaintiff
- ☐ Ward of Court
- ☐ Other _____

SECONDARY INSURANCE CARRIER

INSURANCE ID# **GROUP#**

SUBSCRIBER NAME (Policy Holder) **DATE OF BIRTH**

ADDRESS **PHONE**

RELATIONSHIP TO PATIENT:

- ☐ Child
- ☐ Dependent
- ☐ Domestic Partner
- ☐ Donor Insured by Rec Patient
- ☐ Father
- ☐ Guardianship
- ☐ Mother
- ☐ Organ Donor Insured by Patient
- ☐ Parent
- ☐ Same as patient
- ☐ Self
- ☐ Sponsored Dependent
- ☐ Spouse
- ☐ Subscriber Covers Injured Plaintiff
- ☐ Ward of Court
- ☐ Other _____

If you are here because of an injury, is it: ☐ **Work Related** ☐ **Auto Related** ☐ **Neither**

DATE OF INJURY

All Payment Is Due at Time of Service

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of service. I will be responsible for fees and charges according to Frederick Health Medical Group and my health plan. If I do not provide a **valid** insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Frederick Health Medical Group and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages and/or an automatic dialing device ("auto dialer"), by text message, or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE **DATE**

RELATIONSHIP TO PATIENT

Health Insurance Portability and Accountability Act (HIPAA)

This form applies to all specialties within Frederick Health Medical Group.

Frederick Health Medical Group

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Frederick Health Medical Group, have been offered a copy of the Notice of Privacy Practice, which describes my privacy rights in accordance to federal and state requirements.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

Communication Consent

I understand that I may be contacted by Frederick Health/Frederick Health Medical Group and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: _____
This communication is to confirm office appointments or leave a message regarding my care.

☐ **No**, please **do not** contact me by the following means: _____

I authorize my provider and the appropriate staff to share medical/billing information about my care/account to the following individuals as indicated below.

NAME RELATIONSHIP PHONE LANGUAGE

Allow disclosure of your healthcare information to this contact? ☐ YES ☐ NO
Authorize staff to speak with this contact regarding: ☐ Appointments ☐ Clinical ☐ Financial

NAME RELATIONSHIP PHONE LANGUAGE

Allow disclosure of your healthcare information to this contact? ☐ YES ☐ NO
Authorize staff to speak with this contact regarding: ☐ Appointments ☐ Clinical ☐ Financial

NAME RELATIONSHIP PHONE LANGUAGE

Allow disclosure of your healthcare information to this contact? ☐ YES ☐ NO
Authorize staff to speak with this contact regarding: ☐ Appointments ☐ Clinical ☐ Financial

It is the patient's responsibility to notify Frederick Health Medical Group of any changes to this form.

PRINT PATIENT'S NAME PATIENT'S DATE OF BIRTH

HOME/CELL PHONE NUMBER (PLEASE CIRCLE ONE)

PATIENT OR LEGALLY RESPONSIBLE PERSON'S SIGNATURE DATE

WITNESS DATE

Breast Surgery

Annual Personal Medical History

Frederick Health Medical Group

PATIENT NAME | DATE OF VISIT | DATE OF BIRTH

REASON FOR YOUR VISIT TODAY

Breast and Reproductive History

Do you have annual clinical breast exams by a health practitioner? ☐ Yes ☐ No

Do you perform self-breast exams regularly (at least every 2 months)? ☐ Yes ☐ No

Have you or your practitioner found any abnormal lumps? ☐ Yes ☐ No
If yes, please explain: _____

Do you have annual mammograms? ☐ Yes ☐ No Date of last mammogram: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No
If yes, provide date and results: _____

AGE OF FIRST PERIOD | DATE OF LAST MENSTRUAL PERIOD | AGE AT MENOPAUSE

AGE WHEN YOU HAD YOUR FIRST CHILD | NUMBER OF PREGNANCIES | NUMBER OF LIVE BIRTHS

Did you breastfeed? ☐ Yes ☐ No If yes, how long for each child? _____

Have you ever taken birth control pills? ☐ Yes ☐ No If yes , are you currently taking them? ☐ Yes ☐ No

Have you ever taken hormone replacement therapy or fertility drugs? ☐ Yes ☐ No
If yes, list names and duration: _____

Any prior breast needle biopsies? (please bring results if possible) ☐ Yes ☐ No

List any prior breast surgeries: _____

Have you ever had Breast Cancer? ☐ Yes ☐ No If yes what type? (if known): _____

Have you ever had Breast/Chest Radiation for treatment purposes? ☐ Yes ☐ No
Reason: _____

What is your ethnic background (for example, German)?: _____

Do you have Eastern European Jewish Heritage in your family? ☐ Yes ☐ No

PATIENT NAME DATE OF VISIT DATE OF BIRTH

Review of Systems Please mark if you are experiencing now or have had symptoms in the past

CONSTITUTIONAL

Chills	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain	☐ YES	☐ NO
Weight Loss	☐ YES	☐ NO

RESPIRATORY

Cough	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO

GENITOURINARY

Abnormal vaginal bleeding	☐ YES	☐ NO
Vaginal Discharge	☐ YES	☐ NO

CARDIOVASCULAR

Chest Pain	☐ YES	☐ NO
Edema	☐ YES	☐ NO
Leg Swelling	☐ YES	☐ NO
Rapid Pounding/ Irregular Heartbeat	☐ YES	☐ NO

GASTROINTESTINAL

Abdominal Pain	☐ YES	☐ NO
Abdominal Mass	☐ YES	☐ NO
Constipation	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO
Nausea	☐ YES	☐ NO
Vomiting	☐ YES	☐ NO
Abdominal Distention	☐ YES	☐ NO

METABOLIC/ENDOCRINE

Cold Intolerance	☐ YES	☐ NO
Heat Intolerance	☐ YES	☐ NO
Excessive Thirst	☐ YES	☐ NO
Extreme Hunger	☐ YES	☐ NO

MUSCULOSKELETAL

Joint Pain	☐ YES	☐ NO
Muscle Weakness	☐ YES	☐ NO

PSYCHIATRIC

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO

HEMATOLOGY/IMMUNOLOGY

Easy Bruising	☐ YES	☐ NO
Lymphadenopathy	☐ YES	☐ NO

NEUROLOGIC

Dizziness	☐ YES	☐ NO
Headache	☐ YES	☐ NO
Memory Loss	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO

SKIN/BREAST

Breast Asymmetry	☐ YES	☐ NO
Breast Dimpling	☐ YES	☐ NO
Breast Swelling	☐ YES	☐ NO
Breast Skin Changes	☐ YES	☐ NO
Breast Pain	☐ YES	☐ NO
Breast Lump	☐ YES	☐ NO
Breast Mass	☐ YES	☐ NO
Nipple Discharge	☐ YES	☐ NO
Nipple Itching	☐ YES	☐ NO
Nipple Skin Changes	☐ YES	☐ NO
Redness	☐ YES	☐ NO
Rash	☐ YES	☐ NO
Wounds	☐ YES	☐ NO
Nipple Inversion/ Retraction	☐ YES	☐ NO

Patient Health History

Frederick Health Medical Group

PATIENT NAME (First, Middle, Last) **DATE OF BIRTH**

OCCUPATION

PRIMARY CARE PROVIDER (First and Last Name) **PHARMACY PREFERENCE** (Include location)

REASON FOR VISIT **DATE OF ONSET OF ILLNESS/INJURY**

Have you fallen in the past year? ☐ Yes ☐ No How many times? _____ Did the fall(s) result in an injury? ☐ Yes ☐ No

Do you use a walking aid or has one been recommended? ☐ Yes ☐ No ☐ N/A Details: _____

Past Medical History Check **all** conditions you have now or have had in the past.

CANCER
☐ TYPE: _____ YEAR: _____

CANCER
☐ TYPE: _____ YEAR: _____

CANCER
☐ TYPE: _____ YEAR: _____

CARDIOVASCULAR *(Heart & Blood Vessels)*
☐ Angina (chest pain)
☐ Arrhythmia/irregular heartbeat
☐ Blood clot/DVT (deep vein thrombosis) DATE: _____
☐ Heart attack/MI DATE: _____
☐ Heart disease/Coronary artery disease
☐ High cholesterol/Hyperlipidemia
☐ MVP (mitral valve prolapse)
☐ Varicose veins/Peripheral vascular disease
☐ Hypertension/High blood pressure
☐ Pacemaker YEAR: _____
☐ Stent DATE: _____
☐ AICD (Automatic Implantable Cardioverter Defibrillator)

BONES, JOINTS & MUSCLES
☐ Arthritis
☐ Fibromyalgia
☐ Gout
☐ Osteoporosis

MENTAL HEALTH
☐ Anxiety DATE: _____
☐ Bipolar Disorder DATE: _____
☐ Depression DATE: _____
☐ Drug/Alcohol abuse DATE: _____
☐ OTHER: _____ DATE: _____

HEENT *(Head, Eyes, Ears, Nose & Throat)*
☐ Blind DATE: _____
☐ Deaf DATE: _____
☐ Hearing loss DATE: _____
☐ Glaucoma DATE: _____

PULMONARY/RESPIRATORY
☐ Asthma
☐ Emphysema
☐ COPD (chronic obstructive pulmonary disease)
☐ PE (pulmonary embolism/blood clot in lung) DATE: _____
☐ Pneumonia
☐ Sleep Apnea
☐ Currently uses a C-PAP machine
☐ TB (tuberculosis) DATE: _____

GENITOURINARY *(Kidneys & Urinary Tract)*
☐ Renal failure
☐ Renal insufficiency
☐ UTI (urinary tract infection)

NEUROLOGIC DISORDER *(Brain & Nervous System)*
☐ Alzheimer's disease
☐ Dementia
☐ MS (Multiple Sclerosis)
☐ Parkinson's disease
☐ Seizure disorder
☐ Stroke/CVA/TIA DATE: _____
☐ Myasthenia gravis
☐ Muscular dystrophy
☐ Migraines
☐ Scoliosis
☐ Rheumatoid Arthritis

HEMATOLOGIC *(Blood & Lymph Node)*
☐ Anemia
☐ Hemophilia
☐ Sickle cell disease
☐ Clotting disorders
☐ Lupus

GASTROINTESTINAL *(Stomach & Digestive)*
☐ Colon polyps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Hepatitis – Type unknown
☐ Hernia
☐ Irritable bowel
☐ Stomach ulcer
☐ Liver disease/Cirrhosis
☐ Acid Reflux
☐ Crohn's Disease
☐ Ulcerative Colitis

ENDOCRINE *(Hormones & Metabolic)*
☐ Diabetes – Type I
☐ Diabetes – Type II
☐ Diabetes – Type unknown
☐ Thyroid dysfunction
☐ Hypothyroidism (low)
☐ Hyperthyroidism (high)
☐ Hemoglobin A1C
☐ Thyroid Cancer

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS
☐ AIDS DATE: _____
☐ HIV positive DATE: _____
☐ MRSA (Methicillin Resistant Staph Aureus) DATE: _____
☐ Lyme's Disease DATE: _____

Other medical conditions not listed above: _____

Past Surgical History Check **all** that apply and indicate which side R/L as appropriate.

- ☐ Joint surgery YEAR: _____ R/L
- ☐ Aneurysm YEAR: _____
- ☐ Angioplasty YEAR: _____
- ☐ Angio w/stent YEAR: _____
- ☐ Appendectomy YEAR: _____
- ☐ Arthroscopy YEAR: _____ LOCATION: _____ R/L
- ☐ Back surgery YEAR: _____
- ☐ Cardiac/Heart surgery YEAR: _____
- ☐ Cataract extraction YEAR: _____ R/L
- ☐ Colectomy YEAR: _____
- ☐ Colonoscopy YEAR: _____
- ☐ C- Section YEAR: _____
- ☐ Ear Tubes YEAR: _____
- ☐ Gallbladder YEAR: _____
- ☐ Gastric bypass YEAR: _____
- ☐ Hernia repair YEAR: _____
- ☐ Hip replacement YEAR: _____ R/L
- ☐ Hysterectomy YEAR: _____ Ovaries: R/L
- ☐ Knee replacement YEAR: _____ R/L
- ☐ Breast Surgery YEAR: _____ R/L
- ☐ Prostate YEAR: _____
- ☐ Thyroidectomy YEAR: _____
- ☐ Tonsillectomy YEAR: _____
- ☐ Tubal Ligation YEAR: _____
- ☐ Vasectomy YEAR: _____

OTHER SURGERIES NOT LISTED:

- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____

☐ Problems with Past Anesthesia (if yes, please list below):

_____

CURRENTLY BEING TREATED WITH:

- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Oxygen (Day/Night) _____ liters

Family History Has any member of your family (blood relatives) had one or more of the following diseases? If so, please mark the checkbox next to the condition and indicate which family member beside the condition name.

- ☐ Cancer/Type _____
- ☐ Cancer/Type _____
- ☐ Cancer/Type _____
- ☐ Cancer/Type _____
- ☐ Heart disease _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Alcoholism _____
- ☐ High blood pressure _____
- ☐ Depression _____
- ☐ Sickle Cell _____
- ☐ Tuberculosis _____
- ☐ Glaucoma _____
- ☐ Asthma _____
- ☐ High Cholesterol _____
- ☐ Kidney disorder _____
- ☐ Dementia _____
- ☐ Gout _____
- ☐ Suicide _____
- ☐ Epilepsy _____
- ☐ Thyroid disorder _____
- ☐ Bleeding disorder _____

Social History

ALCOHOL USE

Do you drink alcohol? ☐ None ☐ Rarely (social) ☐ Often # of Drinks per week: _____ ☐ Quit If so, when? _____

What type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Hard liquor

CAFFEINE USE

☐ Daily AMOUNT & TYPE _____ ☐ Sometimes AMOUNT & TYPE _____ ☐ Never

TOBACCO USE: PRESENT

Do you currently smoke cigarettes regularly (at least one a day)? ☐ No ☐ Yes

Currently on average, how many cigarettes do you smoke per day? (one pack = 20) # OF CIGARETTES: _____

TOBACCO USE: PAST

In the past, have you ever smoked cigarettes regularly (at least 100 cigarettes)? ☐ No ☐ Yes

How many years have you smoked cigarettes regularly (at least once a day)? _____ YEARS

In the past on average, how many cigarettes did you smoke per day? (one pack = 20) # OF CIGARETTES: _____

If you have quit smoking, what year did you quit? _____

Do you currently smoke cigars/pipe/smokeless tobacco? ☐ No ☐ Yes

VAPING

Do you vape? ☐ Not currently ☐ Currently If you currently vape, how long have you been vaping? _____

What type of device(s) do you use? _____ Current Strength: Previous Strength:

How many times per day do you vape? _____

Do you vape for social reasons or in an effort to quit smoking? _____

Social History, continued

DRUG USE

Present ☐ No ☐ Yes If you answered "Yes," what type(s)? _____

Past ☐ No ☐ Yes If you answered "Yes," what type(s)? _____

Age quit: _____ Date quit: _____

Medications Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements, and over-the-counter medications.

MEDICATION	DOSAGE/DIRECTIONS	PROBLEM BEING TREATED	PRESCRIBING DOCTOR

☐ **Medication List Copied**—see attached Medication List

Are you being treated by pain management? ☐ Yes ☐ No If so, where? _____

Allergies Please indicate your known allergies using the checkboxes below:

☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Latex
☐ Betadine
☐ Tape
☐ IVP dye
☐ Iodine/shellfish
☐ Eggs, birds/feathers
☐ Contact dermatitis
☐ Other: _____
☐ **I have no known allergies**

Please describe your reaction(s) to allergens, if any: _____

Current Treating Physicians

CARDIOLOGIST	PULMONOLOGIST	NEUROLOGIST
ENDOCRINOLOGIST	HEMATOLOGIST/ONCOLOGIST	OTHER

PATIENT/GUARDIAN SIGNATURE DATE OF BIRTH DATE