Patient Registration

Frederick Health Medical Group

Patient Information

PATIENT NAME (First, Middle, Last, Suffix) _____ **PREFERRED FIRST NAME** _____ **DATE OF BIRTH** _____

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

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

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

WOULD YOU LIKE TO JOIN THE PATIENT PORTAL? ☐Yes ☐No **EMAIL ADDRESS** (required for the portal): _____

PRIMARY CARE PROVIDER: _____ **REFERRING PROVIDER** (ifapplicable): _____

EMPLOYER: _____

OCCUPATION: _____

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

EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____

PRIMARY LANGUAGE: _____ **INTERPRETER NEEDED?** ☐Yes ☐No

ORGAN DONOR: ☐Yes ☐No **VETERAN STATUS:** _____

MARITAL STATUS

- ☐ Annulled
- ☐ Choose Not To Disclose
- ☐ Divorced
- ☐ Legally Separated
- ☐ Life Partner
- ☐ Married
- ☐ Married, CommonLaw
- ☐ Single
- ☐ Unknown
- ☐ Widowed

PRONOUN

- ☐ Choose not to disclose
- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Their
- ☐ Ze/Hir
- ☐ Not Listed (please specify): _____

BIRTH SEX

- ☐ Female
- ☐ Male
- ☐ Undifferentiated

LEGAL SEX

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Other
- ☐ Unknown/Undifferentiated

RACE

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

ETHNICITY

- ☐ Decline to Answer
- ☐ Cuban
- ☐ Hispanic orLatino
- ☐ Mexican or Chicano
- ☐ Not Hispanic orLatino
- ☐ Other Hispanic Origin
- ☐ Puerto Rican
- ☐ Unknown/Unable to Answer

SEXUAL ORIENTATION

- ☐ Decline to Answer
- ☐ I Don't Know
- ☐ Straight/Heterosexual
- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian/Gay/Homosexual
- ☐ Pansexual
- ☐ Queer
- ☐ If not listed, describe if you are comfortable: _____

GENDER IDENTITY

- ☐ Decline to Answer
- ☐ Female
- ☐ Male
- ☐ Non-binary/Genderfluid
- ☐ Transgender Female (Male-to-Female)
- ☐ Transgender Male (Female-to-Male)
- ☐ If not listed, describe if you are comfortable: _____

CONTINUED ON REVERSE

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID# **GROUP#**

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

ADDRESS **PHONE**

RELATIONSHIP TO PATIENT:

☐ Same as Patient ☐ Parent

☐ Spouse ☐ Other _____

SECONDARY INSURANCE CARRIER

INSURANCE ID# **GROUP#**

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

ADDRESS **PHONE**

RELATIONSHIP TO PATIENT:

☐ Same as Patient ☐ Parent

☐ Spouse ☐ Other _____

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

DATE OF INJURY

Responsible Party/Guarantor

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

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

RELATIONSHIP ☐ Parent ☐ Guardian ☐ Self

TO PATIENT: ☐ Spouse ☐ Other _____

SEX: ☐Female ☐Male ☐Undifferentiated

Emergency Contact

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

Consent Agreement Form

Frederick Health
Medical Group

Consent to Treat

I consent (on my behalf or on the behalf of the Patient) to and authorize physicians, physician assistants, nurse practitioners, and other health care providers at Frederick Health Medical Group to provide such diagnosis, care and treatment deemed necessary for my care. I consent to the presence of observers and persons providing technical support and advice for the purposes of advancing education or enhancing my medical care. I understand that I have the right to make informed decisions about my health care, including the right to refuse care, and to revoke, in writing the consent to any services, procedure or treatment that has not already been provided. I understand and agree that it is my obligation to comply with all reasonable instructions of my health care providers in order to secure the best possible outcome.

INITIALS **DATE**

Assignment of Benefits

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of service. Co-payments are due at the time of the office visit therefore I understand that I cannot ask for my co-pay to be billed. If I cannot pay my co-pay at the time of visit, I may have to reschedule my appointment. 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.

INITIALS **DATE**

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.

INITIALS **DATE**

Telemedicine Consent

Frederick Health Medical Group provides telemedicine as an option for certain appointments. Should I be offered and elect to participate in a telemedicine visit, I understand that care may be delivered using electronic communication technologies, and I acknowledge the associated benefits and potential risks, including technological or privacy limitations. I affirm that I will be located in the State of Maryland at the start of any telemedicine encounter.

INITIALS **DATE**

Advanced Care Technology

Frederick Health is dedicated to providing optimal care. To improve efficiency and allow focus on individual needs, Artificial Intelligence (AI) tools may be used to assist with medical documentation, information gathering, and other use cases as technology advances.

For example, the AI technology that may be used in your appointment/provider encounter assists with transcribing and summarizing discussions that are recorded by the tool. You may opt out of using this AI transcription technology by notifying your health care provider at the time of your appointment.

Healthcare providers will review, edit, and finalize all AI-assisted documentation to ensure accuracy. AI does not replace human medical expertise or decision making.

INITIALS **DATE**

PRINT PATIENT'S NAME

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE **DATE**

REV 3/2026

Health Insurance Portability and Accountability Act (HIPAA)

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

Frederick Health
Medical Group

Communication Consent

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 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 of **HIPAA Contact**	RELATIONSHIP	PHONE NUMBER
NAME of **HIPAA Contact**	RELATIONSHIP	PHONE NUMBER

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

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