

## Hello, and welcome to Frederick Health Medical Group!

We appreciate the value of your time. Here are some tips to help us provide comprehensive care in an efficient manner:

- Please bring your insurance card and photo ID with you.
- Payment is expected at time of service. We accept cash, checks, and all major credit cards.
- For patients visiting one of our specialists: if you are a member of an HMO, please contact your primary care physician to obtain a referral. Most offices require 48 hours' notice to issue a referral.
- For all new patients to our practices, please have appropriate records forwarded to us before your appointment. Your Doctor's office will either mail or fax them to our office, but you must request them. This includes any recent office notes, labs, or imaging.
- **Please complete the attached paperwork** and have it ready when you arrive for your visit.
- **You may be asked to reschedule if you arrive after your check in time.**

We are working hard to ensure your time with us is as pleasant as possible. We are committed to your care and value any feedback you may have for us. Thank you and we look forward to seeing you!

Respectfully,

Your providers and staff at Frederick Health Medical Group

## Contact Us

Audiology	<b>301-695-EARS (3277)</b>
Behavioral Health	<b>240-566-3904</b>
Breast Surgery	<b>301-418-6611</b>
Chest Surgery	<b>301-694-5861</b>
Endocrine & Thyroid	<b>240-215-1454</b>
Ear, Nose & Throat (Otolaryngology)	<b>301-695-3100</b>
Medical Weight Loss	<b>240-215-1474</b>
Oncology & Hematology	<b>301-662-8477</b>
Orthopedics & Sports Medicine	<b>301-663-9573</b>
Primary Care	<b>240-215-6310</b>
Sleep Medicine	<b>240 566-REST (7378)</b>
Supportive & Geriatric Care	<b>240-566-3031</b>
Surgery	<b>240-575-2526</b>
Urology	<b>301-663-4774</b>
Wound & Hyperbaric Medicine	<b>240-566-3840</b>

# Patient Compact

## Principles of Partnership

### As your healthcare partner, we pledge to:

- Respect you as leader of the team.
- Allow you to select a personal provider and care team who will know you.
- Treat you with respect, honesty and compassion.
- Include your family, other partners or an advocate in your care when you request.
- Hold ourselves to the highest quality and safety standards.
- Be responsive and timely with our care and information to you.
- Listen to you and answer your questions.
- Provide information to you in a way you can understand.
- Help you to set goals for your healthcare and treatment plans.
- Provide you with information to help you make informed decisions about your care and treatment options.
- Communicate openly about benefits and risks associated with any treatments.
- Respect your right to your own medical information.
- Respect your privacy and the privacy of your medical information.
- Work with you, and other partners who treat you, in the coordination of your care.
- Provide educational resources, information about classes, support groups, or other services that can help you learn more about your condition.

### As a patient, I pledge to:

- *Be a responsible and active member of my healthcare team, and participate in decisions about my care.*
- *Treat the whole team with respect, consideration and always tell the truth.*
- *Give you the information that you need to treat me.*
- *Tell you what medications/supplements I am taking.*
- *Inform you of all other provider visits, tests ordered, and medications prescribed by them and have them send us reports of your visit.*
- *Tell you if something about my health changes and any changes in my family, medical and social history.*
- *Learn about my health condition and let you know if there is something I do not understand.*
- *Understand my care plan to the best of my ability and follow my care plan that I have agreed upon or let you know if there are issues so the plan can be changed.*
- *Take all medications as prescribed and communicate to my team if there are issues such as cost or side effects.*
- *Communicate any questions using the patient portal or by phone.*
- *Tell you if I have trouble reading or hearing.*
- *Let you know if I have family, friends or an advocate to help me with my healthcare.*
- *Work with Frederick Health Medical Group and my insurance company to understand what my insurance plan covers. I will pay my share of any fees.*

# A BETTER APPROACH TO YOUR HEALTHCARE

No matter your health needs, your primary care provider is here to help you maintain a healthy lifestyle. Evidence shows that access to primary care helps people live longer, healthier lives\*—and patients with access to regular primary care providers have lower overall healthcare costs.\*\*



## What is a patient-centered medical home (PCMH)?

It's an innovative approach to primary care that meets patients where they are—in the right place, at the right time, and with the right care.



### Accessible

Shorter wait times, "after-hours" care, 24/7 telehealth access, and stronger communication



### Committed to quality and safety

Evidence-based medicine and clinical support



### Comprehensive

A team of care providers—from physicians to nurses to nutritionists to social workers—for prevention, wellness, acute care, and chronic care



### Coordinated

Open communication across all parts of the broader healthcare system, especially during transitions between sites of care



### Patient-centered

Provides the education and resources you need to make smart decisions and become an active participant in your own care



### Personalized

Addresses your personal health concerns and needs



### Supportive and encouraging

Advice via phone, email, text, etc. from your health team to help you meet your goals and support you with health issues and concerns



### Efficient

Saves you time

\* Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/#b62>

\*\* Source: <https://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf>

It's not a place—it's a partnership with your primary care provider.

# WHEN YOU THINK PCMH, THINK FREDERICK HEALTH MEDICAL GROUP!



## Why Frederick Health Medical Group?

Frederick Health Medical Group is recognized by the National Committee of Quality Assurance as a PCMH. We partner with you and your healthcare team to provide the highest level of primary care possible.



## With Frederick Health Primary Care, your healthcare team...

- Is just a phone call or portal message away
  - Is your access point to Frederick Health and its wide array of services and specialists
  - Collaborates with specialists to address all aspects of your healthcare
  - May include a number of specialists, like in-house care coordinators, patient navigators, lab assistants, licensed clinical social workers, and more
  - Offers telehealth, including email messaging and nurse access via the phone
  - Offers the same level of service and care, no matter your insurance provider or payer
- ✓ 8 locations in Frederick, Myersville, and Mt. Airy
  - ✓ Lower hospital readmission rates after a health event
  - ✓ National Committee for Quality Assurance certified
  - ✓ Open 7 days a week
  - ✓ Same-day appointments and walk-ins

# Choosing the Right Level of Care

in a Medical Emergency



Everyone knows that a primary care doctor is the best place to go when you are sick or in pain. By seeing your primary care physician on a regular basis, they will have your complete health history and an understanding of any underlying conditions you may have.

Sometimes you become sick or injured when the doctor's office is closed, and sometimes you need more urgent medical attention than your doctor can provide. This handout helps to explain **where to seek the best care in your time of need.**

**Primary Care** Call to make an appointment with your primary care provider if you have symptoms of a regular illness or need a regular check-up.

- Treatment of illness, including:
  - Colds and coughs*
  - Sore throat*
  - Flu and flu-like symptoms*
  - Ear infections*
  - Urinary tract infections*
  - Minor aches and pains*
  - Allergies*
- Management of chronic conditions, such as:
  - Diabetes*
  - Heart Disease*
  - COPD*
- General medical advice
  - Annual Well Exams
  - Immunizations
  - Respiratory problems

**If you believe a life is in jeopardy, always call 911!**

**Urgent Care** is an option if you have a minor illness or injury, your primary care provider is not available, and your problem cannot wait.

- Treatment of illness, including:
  - Colds, coughs, and upper respiratory infections;*
  - Sore throat;*
  - Flu and flu-like symptoms;*
  - Ear infections/Earache;*
  - Suspected urinary tract infection;*
  - Sexually Transmitted Illness;*
  - Fever* **If having seizures, go to the Emergency Department**
- Upset stomach
- Nausea or vomiting
- Adult IV hydration
- Skin rashes and infections
- Abscesses
- Sprains or suspected minor broken bones
- Musculoskeletal injuries
- Back pain or joint pain
- Toothache (if dentist is not available)
- Allergies
- Animal or insect bite
- Eye irritation and redness
- Minor cut/abrasion and sutures/stitching
- Minor burn
- Frequent, bloody, or painful urination
- Motor Vehicle Collision exams
- Workman's Comp exams
- Sports/DOT physicals
- Travel vaccines
- Laboratory and blood work
- X-Rays

**The Emergency Department (ED)** is open 24 hours a day, 7 days a week. You should seek care at the Emergency Department without delay if you have a serious or a life-threatening illness or injury.

- Chest pain or other heart attacks symptoms, such as:  
*Pressure, fullness, squeezing/pain in the center of your chest*  
*Tightness/burning/aching under the breastbone*  
*Chest pain with lightheadedness*
- Signs of a stroke, such as:  
*Sudden weakness or numbness of the face/arm/leg on one side of the body*  
*Sudden dimness or loss of vision*  
*Loss of speech or trouble talking*  
*Sudden severe headaches with no cause*
- Head injury or eye injury
- Sudden and severe headache or loss of vision
- Heavy bleeding that won't stop
- Dislocated joints
- Severe abdominal pain
- Deep cuts or severe burns
- High fever
- Severe asthma attack
- Loss of consciousness
- Severe or worsening reaction to an insect bite, sting, or medications
- Constant, severe/persistent vomiting
- Coughing up or vomiting blood
- Poisoning **Call Poison Control at 1-800-222-1222 and ask for immediate home treatment advice**
- Domestic violence or rape
- Feelings of suicide

**If you believe a life is in jeopardy, always call 911!**

# Patient Registration



## 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)
PREFERRED CONTACT METHOD (Check all that apply): <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Home Address (Letter) <input type="checkbox"/> Portal			
PRIMARY LANGUAGE	EMPLOYMENT STATUS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military <input type="checkbox"/> Homemaker <input type="checkbox"/> Unknown		
EMPLOYER	STUDENT STATUS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student		

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE DAYTIME	EVENING
BIRTH SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Undifferentiated	LEGAL SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/Undifferentiated <input type="checkbox"/> Non-binary <input type="checkbox"/> Other	SEXUAL ORIENTATION <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Something else (please describe): _____	MARITAL STATUS <input type="checkbox"/> Annulled <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Married <input type="checkbox"/> Married, Common Law <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed
PRONOUN <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> He, Him, His <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Ze, Hir	GENDER IDENTITY <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively Male nor Female <input type="checkbox"/> Additional gender category or other (please specify): _____		

RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Decline to Answer <input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Black/African American <input type="checkbox"/> Unknown/Unable to Answer <input type="checkbox"/> Other: _____	ETHNICITY <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Decline to answer <input type="checkbox"/> Mexican or Chicano <input type="checkbox"/> Other Hispanic Origin <input type="checkbox"/> Unknown/Unable to answer
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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: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____
ADDRESS	HOME PHONE	WORK PHONE	SEX: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Undifferentiated

## Insurance Information

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**PRIMARY INSURANCE CARRIER**

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**INSURANCE ID#****GROUP#**

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

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**ADDRESS****PHONE****RELATIONSHIP TO PATIENT:**

- |   |  |
|---|--|
| <input type="checkbox"/> Child                          | <input type="checkbox"/> Parent                              |
| <input type="checkbox"/> Dependent                      | <input type="checkbox"/> Same as patient                     |
| <input type="checkbox"/> Domestic Partner               | <input type="checkbox"/> Self                                |
| <input type="checkbox"/> Donor Insured by Rec Patient   | <input type="checkbox"/> Sponsored Dependent                 |
| <input type="checkbox"/> Father                         | <input type="checkbox"/> Spouse                              |
| <input type="checkbox"/> Guardianship                   | <input type="checkbox"/> Subscriber Covers Injured Plaintiff |
| <input type="checkbox"/> Mother                         | <input type="checkbox"/> Ward of Court                       |
| <input type="checkbox"/> Organ Donor Insured by Patient | <input type="checkbox"/> Other _____                         |

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**SECONDARY INSURANCE CARRIER**

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**INSURANCE ID#****GROUP#**

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

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**ADDRESS****PHONE****RELATIONSHIP TO PATIENT:**

- |   |  |
|---|--|
| <input type="checkbox"/> Child                          | <input type="checkbox"/> Parent                              |
| <input type="checkbox"/> Dependent                      | <input type="checkbox"/> Same as patient                     |
| <input type="checkbox"/> Domestic Partner               | <input type="checkbox"/> Self                                |
| <input type="checkbox"/> Donor Insured by Rec Patient   | <input type="checkbox"/> Sponsored Dependent                 |
| <input type="checkbox"/> Father                         | <input type="checkbox"/> Spouse                              |
| <input type="checkbox"/> Guardianship                   | <input type="checkbox"/> Subscriber Covers Injured Plaintiff |
| <input type="checkbox"/> Mother                         | <input type="checkbox"/> Ward of Court                       |
| <input type="checkbox"/> Organ Donor Insured by Patient | <input type="checkbox"/> Other _____                         |

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

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**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.

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**PATIENT SIGNATURE OR PATIENT REPRESENTATIVE****DATE**

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**RELATIONSHIP TO PATIENT**



# Patient Health History

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: \_\_\_\_\_

Other medical conditions not listed above: \_\_\_\_\_

## 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: \_\_\_\_\_

**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: \_\_\_\_\_

- 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:

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Betadine             | <input type="checkbox"/> Contact dermatitis               |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tape                 | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> IVP dye              | <input type="checkbox"/> <b>I have no known allergies</b> |
| <input type="checkbox"/> Sulfa      | <input type="checkbox"/> Iodine/shellfish     |   |
| <input type="checkbox"/> Latex      | <input type="checkbox"/> Eggs, birds/feathers |   |

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 \_\_\_\_\_

# Authorization for Use and Disclosure of Health Information



All starred fields are required and must be completed.

PATIENT NAME*		DATE OF BIRTH* / /	
ADDRESS*	CITY*	STATE*	ZIP*
EMAIL ADDRESS*	PHONE*		

I request that my Protected Health Information (PHI) from:

DR. (FIRST NAME)*	LAST NAME*		
ORGANIZATION NAME	PHONE*	FAX*	
ADDRESS*	CITY*	STATE*	ZIP*

Be disclosed to:

RECIPIENT NAME*	PHONE*	FAX*	
ADDRESS*	CITY	STATE	ZIP

I authorize the following PHI to be released from my medical records\* (please select all applicable options):

- Specific Dates: \_\_\_\_\_ to \_\_\_\_\_ or  Full copy of record
- Office Visits from: \_\_\_\_\_  Immunizations  Sleep Study Reports  Preventative Exams
- Radiology Reports  Surgery Consults  Laboratory Reports  Pathology Reports
- Other \_\_\_\_\_

**Purpose for request:**  Legal  Insurance  Personal  Continuation of Care  Other: \_\_\_\_\_

**Disclosure Format:**  US Mail (paper)  US Mail (Electronic)  Fax (Healthcare provider only)

State and Federal Law protects the following. If this applies to you, please indicate if you would like this information released/obtained\* (please select all applicable options):

- Alcohol, Drug, or Substance Abuse Records  Yes  No Dates: \_\_\_\_\_
- HIV Testing and Results  Yes  No Dates: \_\_\_\_\_
- Mental Health Records  Yes  No Dates: \_\_\_\_\_

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to fees in accordance with federal/state regulations.

\* INDICATES REQUIRED FIELD

CONTINUED ON REVERSE SIDE

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented, mailed or faxed to the appropriate location listed above. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire** on the following date/event/condition\*:  
\_\_\_\_\_
- If I fail to specify an expiration date, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization, unless the treatment is part of a research project that requires this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

**I understand and agree to the Authorization terms.**

/	/	/	/
SIGNATURE OF PATIENT*	DATE/TIME*	SIGNATURE OF WITNESS	DATE/TIME

**If you are signing as a Representative for the above patient, you will be asked to provide ID.**

YOUR NAME (PLEASE PRINT)	RELATIONSHIP TO PATIENT
YOUR SIGNATURE	DATE / / TIME

**When this form is completed, please send by mail or fax ONLY to this address:**

**Frederick Health Medical Group  
Attn: CBO - Medical Records - 3<sup>rd</sup> Floor  
1 Frederick Health Way  
Frederick, MD 21701  
240-566-7751**

**DO NOT drop off the form in person.**

To make sure that your request is processed efficiently and within a timely manner, please note the following:

- All starred fields are required and must be completed.
- If you are requesting medical records for someone other than yourself:
  1. *Minors require a Parent/Legal Guardian*
  2. *Adults require a copy of the POA (Power of Attorney), indicating that you have the right on the patient's behalf*
  3. *Deceased patients require a copy of an updated POA (Power of Attorney) or court documentation establishing estate executorship*

Frederick Health Medical Group has contracted with CIOX; an outside vendor, to meet the needs of our patient's medical records copying requests. For any questions regarding a request, please contact us at 240-215-6310.

\* INDICATES REQUIRED FIELD