MARYLAND SURGEONS

Date_____

Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex _____ Marital Status _____

Home Phone # _____ Work Phone # _____ Cell# _____

Employer _____ Occupation _____

Employed: __ Full Time __ Part Time __ Retired Student: __ Full Time __ Part Time

Person to Notify in an Emergency _____

Relationship _____ Phone Number _____

Primary Care Physician _____ Referring Physician _____

Insurance Information:

Primary Insurance _____

Are you the policyholder? _____Yes ____No (*this information is NOT on the card*)
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Secondary Insurance _____

Are you the policyholder? _____Yes ____No
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Insurance Authorization & Information Release

I hereby authorize St. Agnes Healthcare to release information from my records to persons who have need for this information such as insurance companies, doctors, and other agencies or professionals involved in my care. St. Agnes Healthcare personnel are authorized to determine which persons or agencies are in need of such information. I hereby authorize Medicare, Medicaid and/or any insurance company(s) to pay St. Agnes Healthcare directly for services provided. I agree to accept financial responsibility for services provided at St. Agnes Healthcare for the patient.

Signature: _____Date:_____

Notice of Privacy Practices/Financial Policy Receipt: I hereby acknowledge that I have received a copy of the St. Agnes Healthcare Joint Notice of Privacy Practices & the Maryland Surgeons Financial Policy.

Signature: _____Date:_____

Please Turn Over

MARYLAND SURGEONS

Date_____

Acknowledgement and Consent

_____ _____
Patient Name – PLEASE PRINT Date of Birth

By signing this form, I consent to MARYLAND SURGEONS/St. Agnes Healthcare use and disclosure of protected health information about me to the persons listed below. I understand that I have the right to revoke this consent in writing, except where MARYLAND SURGEONS/St. Agnes Healthcare has already made disclosures in trust on my prior consent.

_____ _____
Signature Date

Please list family members or others with whom we may discuss your **medical information** or **account information**. **Please designate by your X in the appropriate column, which information we may discuss with each party listed.**

Name	***Relationship***	***Medical***	***Account***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

So that we may better assist you in the future, please provide the following:

Email address: _____

Pharmacy: _____ City: _____

Pharmacy Phone #: _____

Please Turn Over

MARYLAND SURGEONS

Date_____

Name: _____ **Primary Care Physician:** _____

Date of Birth: _____ **Age:** _____ **Referring Physician:** _____

1. **Reason for visit:** _____

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

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:** _____

Please Turn Over

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:_____

Please Turn Over

MARYLAND SURGEONS

Date_____

Patient Name:_____ Date of Birth: _____

BREAST HEALTH QUESTIONNAIRE

Do you examine yourself regularly? ___ Yes ___ No How often? _____

When do you examine yourself in relation to menstruation? _____

Do you see a physician for breast exams? ___ Yes ___ No How often? _____

Date of last check up: _____ Name of physician: _____

Have you ever had a mammogram? ____ Yes ____ No

Date of last mammogram: _____

Have you ever had nipple discharge? __ Yes __ No Which breast? ____ Left ____ Right

Any infection or injury to the breast? __ Yes __ No Which breast? ____ Left ____ Right

Any family history of breast cancer? __ Yes __ No If so, who? _____

Any previous breast surgery? __ Yes __ No When? _____

At what age did you start menstruation? _____ Date of last menstrual period:_____

How many pregnancies have you had? _____ How many children do you have? _____

How old were you at the birth of your 1st child? _____

Did you breastfeed? ____ Yes ____ No If yes, how long? _____

Do you take birth control pills? ____ Yes ____ No In the past? ___ Yes ____ No

If yes, how long? _____

Do you take hormones? _____ Yes _____ No If yes, how long? _____

At what age did you stop menstruating (menopause)? _____

Please Turn Over

MARYLAND SURGEONS

Date_____

Baltimore Office on the St. Agnes Hospital Campus
Angelos Medical Pavilion
3407 Wilkens Ave., Suite 410
Baltimore, MD 21229
Phone: 443.574.8500 // Fax: 410.719.0094

From Baltimore Beltway 695 - Exit 12 Wilkens Avenue East. Travel approximately 2 miles east. Turn right at the traffic light into the Campus of St. Agnes Hospital. The Angelos Pavilion is the building immediately to your left as you enter the campus. Park in Lot F, in front of the building.

From Interstate 95 - Exit 50, north to Caton Ave. Travel north on Caton < 1 mile. Turn left at the light onto the Campus of St. Agnes Hospital. Wind through the Campus following signs for Angelos Medical Pavilion. The Angelos Medical Pavilion is the last building on the right before exiting hospital campus. Park in Lot F, in front of the building.

Columbia Office between Howard County General Hospital and Howard Community College
Medical Pavilion at Howard County
10710 Charter Drive, Suite 230
Columbia, MD 21044
Phone: 443.574.8500 // Fax: 443.708.9315

Local directions:
From The Mall in Columbia drive westbound on Little Patuxent Parkway (Route 175).
Continue past Howard County General Hospital and turn left onto Cedar Lane.
Turn left onto Hickory Ridge Road.
Turn left onto Charter Drive and continue to the MPHC, which is the second building on the right.

From Route 32:
Exit onto Cedar Lane and continue to Hickory Ridge Road.
Turn right onto Hickory Ridge Road.
Turn left onto Charter Drive and continue to the MPHC, which is the second building on the right.

From all other points:
Take Route 29 towards Columbia.
Exit onto Broken Land Parkway toward Columbia Town Center/Merriweather Post Pavilion.
Turn left onto Hickory Ridge Road.
Turn right onto Charter Drive and continue to the MPHC, which is the second building on the right.

Please Turn Over

MARYLAND SURGEONS

Date_____

Financial Policy

Maryland Surgeons

Patient Financial Policy

1. We have outlined our financial policy below. If you have any questions about the policy, please discuss them with our Patient Accounting Department. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.
2. Full payment of any amount that is your financial responsibility is due at time of service. For your convenience, we will accept VISA, Discover and MasterCard.
3. We have a participating agreement with many insurers and other health plans. We will bill those plans for whom we have an agreement and will require you to pay the designated co-payment at the time of service.
4. We will collect the co-payment when you arrive for your appointment. If your insurance plan requires you to have a written referral, we must have the referral before the service is rendered in order for the service to be covered. If the appropriate referral and/or co-payment are not present, the visit will be rescheduled, unless there is an immediate or urgent medical need for treatment.
5. As a courtesy, we will file your insurance claim for you with insurance companies with whom we do not have a participating contract. We will bill you directly for any patient liability; that is, applicable deductible, copays, coinsurance, etc. If your plan is not an HMO and your insurance company does not pay within six months from date of service, we will look to you for payment.
6. All health plans are not the same and do not cover the same services. In the event you do not have HMO coverage and your health plan determines a service to be "non-covered," you may be responsible for the complete charge. Payment is due upon receipt of a statement from our office. For services that are known to be non-covered by an HMO before they are rendered, you will be required to sign a financial responsibility form acknowledging your responsibility for payment.
7. If you wish to see our doctors for consultation and you are not covered by health insurance, all fees are to be paid at time of service. If you require surgery and you are not covered by health insurance, you must contact our Patient Accounting Department before the surgery will be scheduled to make payment arrangements. A deposit is required before the surgery.
8. Accounts not paid within our routine billing cycle of ninety-one days will be turned to collections. These accounts will be subject to additional fees – collection fees, legal fees and interest.
9. If at any time, during the course of treatment your healthcare coverage changes, please notify us immediately. Each insurance plan has different requirements for authorization and pre-certification of services. Some insurance plans require that certain procedures be performed by particular providers or in certain facilities with whom they have contracted in order to be covered. It is essential that we have correct insurance information when scheduling any procedure for you.
10. If at any time you are unable to make payment of the amounts you have been billed, call us as soon as possible to discuss the situation in order to avoid unnecessary collection and legal costs.
11. There is a $35.00 fee for any returned checks.
12. There may be a $100 fee for cancellation of surgery, for reasons other than medical.

Please Turn Over