SAINT AGNES HEALTHCARE

Steven C. Cunningham, MD, *443-574-8500*

Name ________________________________ Social Security # ____________________

Address ______________________________ Date of Birth ______________________

City ________________ State _____ Zip ______ Sex ______ Marital Status _________

Home Phone # ______________ Work Phone # ______________ Cell# __________________

Employer ___________________ Occupation _______________ Race: ___________________

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 ______________

<u>Insurance Authorization & Information Release</u>

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:_______________________

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*

Other Health Care Providers

GYN Name______________________________Phone _________________Fax____________

Gastroenterologist _________________________Phone_________________Fax_____________

Oncologist ________________________________Phone_________________Fax_____________

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

Email address: ____

Pharmacy: ____________________________ City: _________________________

Pharmacy Phone #: ___________________________

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New Patient Medical History Form

Name: ____________________________ **DOB and age**: _________________ **Date**:__________________

Referring doctor(s): ____
Last name First Name Phone Fax

Reason for referral: ____

Symptoms (circle all that apply): Pain Nausea Bulge or mass Diarrhea Bleeding Itching None
Other: _____________________________________ Symptoms started on: ___________________
Character of pain: Dull Sharp Tearing Burning Crampy None Other: _____________________
Symptoms are: Mild Moderate Severe; Pain score (0-10): At worst _______ and now _________
Pain: Is constant Comes and goes Lasts how long: _____________________________________
What makes symptoms better: __________________; What makes them worse: ____________________
Other information about your symptoms: ____
____

Previous CT, MRI, US, or other tests: ____
____

Please list all **Medical Problems**:
____
____
____
____
____
____

Please list all **Operations** and dates as best as you can recall:
____
____
____
____
____

Please list all **Medications** and doses if you know them:
____
____
____
____
____
____

Allergies: ____

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Name: ___________________________ **DOB and age**: _________________ **Date**:__________________

Please list any **Family Medical History**:

____
____

Social History (check, fill in the blanks, or circle):

I am Married Single Divorced Widowed; I live with: _____________________________________
Number of children: _________ and ages: ____

I am currently working as a ______________________________ at _______________________________
I used to work as a _______________________________________ but _____________________________
[] I am currently smoking _________ packs per day and have been smoking for _________ years.
[] I smoked _________ packs per day for _________ years but quit in _________.
[] I have never smoked.
[] I currently have _________ alcoholic drinks per day and have been drinking for _________ years.
[] I used to drink _________ drinks per day for _________ years but now _______________________.
[] I have never drunk alcohol.
[] Any recent recreational drug use: ____; or [] None.

Please carefully read this **Review of Symptoms:**

Check "None" or Circle any that apply below:		
GENERAL	[] None	Weight loss or gain, fatigue, fever, night sweats, or change in appetite. How many blocks or flights of stairs you can climb: ________________.
INTEGUMENTARY	[] None	Rashes, itching, tattoos, or color change.
HEENT	[] None	Headaches, vision changes, or enlarged nodes or glands.
RESPIRATORY	[] None	Cough, wheezing, shortness of breath, or asthma.
CARDIAC	[] None	Chest pain, heart flutter, or heart murmurs.
GASTROINTESTINAL	[] None	Nausea, vomiting, change in bowel habits, bleeding, constipation, diarrhea, abdominal pain, bloating, hepatitis, light-colored or floating stool, or reflux.
ENDOSCOPY	[] None	Date of last colonoscopy: _________. Last upper endoscopy: _________.
GENITOURINARY	[] None	Painful, difficult, frequent urination, incontinence, or dark urine.
RENAL	[] None	Kidney stones or other problems.
ENDOCRINE	[] None	Thyroid problems or diabetes.
MUSCULOSKELETAL	[] None	Weakness or joint pains.
NEUROLOGICAL	[] None	Fainting, seizures, stroke, loss of vision, or trouble speaking.
HEMATOLOGIC	[] None	Easy bruising or bleeding, anemia, or blood transfusion.
VASCULAR	[] None	Leg pain when walking, blood clots, stroke.
INFECTIOUS	[] None	Recent infections. I take antibiotics before dental procedures.
BREAST	[] None	Pain, history of lumps, or nipple discharge. Last had a mammogram on ______________.
GYNECOLOGIC	[] None	Vaginal bleeding or discharge.

Reviewed by physician: ____

Steven C. Cunningham, M.D.
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