Patients Name: ____

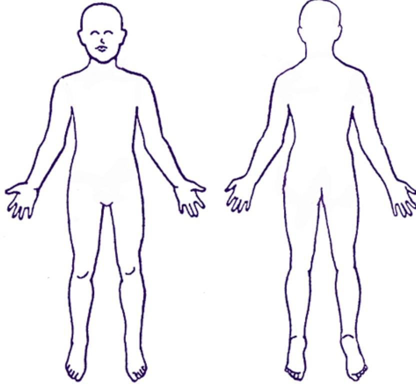
Patient Medical History Form

Describe briefly your present symptoms:

____

____

Please circle all the locations of your pain:



Surgeries: Type Year

____

____

____

Hospitalization: Reason Year

____

____

____

Previous treatment for this problem: (Check all that apply)
-Physical Therapy _____ -Steroid Injections_____
-Surgery _____ -Aquatic Therapy_____

Past medical history (Please include all previous diagnosis):
____
____

SOCIAL HISTORY:
Do you: (Check all that apply)

Smoke____ **Former Smoker** ____ When did you quit? ________

Drink alcohol ____ How **often**: Occasionally____ 1-2 times a week ____ Daily____ Other___________
Exercise Regularly ____ **Have tattoos** ____ **Sexually Active:** _____
Have Children____ If yes, how many: Sons____ Daughters____
Travel outside the USA ____ Please list most recent (Last 10 years, include year)

____

Blood Transfusion ____ If yes, what year? ______
HIV Tested _____ Positive/Negative? (Circle One) What year were you last tested? _______
Been diagnosed with an STI ____ If yes, please list:

____

Recreational drug use____ Yes ___ No ___ If yes, please list:

____

Marital Status:
Married ____ Single ____ Divorced ____ Widowed ____ Separated ____
Employment: Currently employed____ Occupation? _____________
Disability____ Unemployed ____ Receiving unemployment ____ Other _______________

Pharmacy: Name_____________________ Address________________________ Phone Number___________________

Primary Care Physician: Name_________________________ Phone Number____________________________

Referring Physician: Name___________________________ Phone Number_______________________

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.):

Drug Name **Strength** **Frequency**

___

___

___

___

___

___

___

___

___

Drug allergies: Yes ___ No ___ (If yes please list the medication and type of reaction)

___

___

FAMILY HISTORY: Please check all that applies, and if family member is alive or deceased.

	Diabetes	Hyper-tension	Heart Disease	Stroke	Mental Illness	Cancer	Rheum Arthritis	Arthritis	Lupus	Gout
Father Alive__ Deceased__										
Mother Alive__ Deceased__										
Maternal Aunt Alive__ Deceased__										
Maternal Uncle Alive__ Deceased__										
Paternal Aunt Alive__ Deceased__										
Paternal Uncle Alive__ Deceased__										
Paternal Grandfather Alive__ Deceased__										
Paternal Grandmother Alive__ Deceased__										
Maternal Grandfather Alive__ Deceased__										
Maternal Grandmother Alive__ Deceased__										
Siblings										
Children										

Office Policies

1. Patients will get a phone call with all abnormal labs and Procedures. All normal lab results will be discussed at the next office visit.

2. Refills of routine prescriptions can be called in or faxed to your pharmacy. Many prescriptions require prior authorization by your insurance plan, and this may take several days to obtain. Certain pain medications **Cannot** be called in; We will mail these prescriptions to you or you can pick them up. Please plan ahead and call 4 days before running out of your medications. We make every effort to call in or fax the prescriptions in as soon as possible, but we do ask that you allow 48 hours turnaround time for prescriptions to be sent to the pharmacy. Pharmacies can fax refill requests to 410-744-8036.

3. Laboratory and Radiology requested by the Physician at the previous visit should be done at least 5 days prior to your appointment to assure we receive the results on a timely manner.

4. **Cancellation/ Missed visit policy**: **Please note that as of March 1, 2010, if you miss your appointment without giving at least 24 hours of notice, you will be charged a fee of $50.00 (This fee will not be covered by your health insurance plan).** Continuous no shows may result in discharge from our practice.

5. Prior to your appointment, the office will contact your insurance company to verify that your insurance is active and will cover your appointment with our office. We will collect information on your deductible, coinsurance and copayment, if applicable.

6. **It is our office policy to collect the office visit fee at the time of service if you have a deductible amount remaining**. You will be asked to pay $300 for a new patient visit ($150 for a return visit) or the remaining of your deductible, whichever is lower. If you have an HSA or HRA, then this policy will not apply to you. Please note if you have a high deductible, your total charges may be more than the amount collected at the time of service and you will receive a bill.

7. Copayment will be collected at time of service, prior to seeing the doctor, with no exception. This is part of our contracts with the insurance companies. Please be sure to bring a form of payment.

8. If your insurance company requires referrals, it is **your responsibility** to bring this referral to your visit and make certain that it is valid every time you make an appointment. **It is your responsibility to make certain we have your referral**. If you do not have a valid referral for your visit and it is denied by your insurance company, you will be responsible for the full amount of the office visit. If you arrive without the proper referral you will be asked to reschedule your appointment or be financially responsible for the visit if you are seen. **Please bring your insurance card and photo ID to each visit.**

9. Benefits for braces, infusible and injectable medications will be checked prior to dispensing. For the medications, if it is more cost effective for you, we will send these medications to your pharmacy to have them delivered to our office for administration. Otherwise, the medication will be supplied by our office and all office billing policies will apply. Braces will be dispensed by our office unless otherwise noted by your insurance company.

10. After your visit, we will submit a claim to your insurance company. Once we have received payment and explanation of benefits, any remaining balance up to the allowed amount will be your responsibility. At this time a statement will be generated and mailed to you. The full amount must be paid within thirty days, unless you have contacted our office and made payment arrangement. **If no payment or arrangement for payment has been made within 90 days the balance will be sent to a collection agency.**

11. If you call your doctor on the weekend or evenings for non-urgent matters you may be charged a $50.00 fee.

12. In case of inclement weather we will try our best to notify you of any closures or delays as far in advanced as possible. However, you are responsible to call and verify that the office is open before your appointment. We value the safety of our patients and employees. You can also check The Nasseri Clinic Facebook page for up to date inclement weather closures and delays.
    (You will not be charged a no show fee due to inclement weather)

I ____, have read and acknowledge receipt of the policies listed above.

Signature: ____________________________________

Consent and Assignment- Please read before signing

MEDICARE: I authorize any holder of medical or other information about me to be released to the Social Security Administration and or its intermediaries or carriers with any information needed for this or related Medicare claim Title (XVII). I permit a copy of this authorization to be used in place of the original and request payment of Medical insurance benefits either to myself or the party who accepts assignment below. I understand that I am responsible for any health insurance deductible, co-insurance (co-pay), and non-covered charges.

BLUE SHIELD OF MARYLAND: I understand the charges of a non-participating physician may exceed the Blue Shield of Maryland, Inc payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductible, co-insurance (co-pay), and non-covered charges.

LEGAL ASSIGNMENT (applicable to Physician Services): The undersigned expressly agrees if, upon default, this matter is referred for collection, the undersigned agrees to pay for attorney fees of (15%) of the outstanding balance at the time of referral, which percentage and the amount of resulting therefore are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

WORKMAN'S COMPENSATION: I understand that if for any reason my worker's compensation carrier denies payment for services that were rendered to myself, I will be financially responsible.

AUTOMOBILE INSURANCE: I understand that once my PIP has been exhausted, I will be financially responsible for any charges incurred in the event our office does not accept my health insurance and services that are not authorized by my health insurance.

INSURANCE- I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

MANAGED CARE: I understand that without an authorization/referral from my HMO/PPO/PPA/POS plan, I will be financially responsible for charges incurred from our clinic.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN:

Signature: ____ Date: ___________________

Relationship to patient: ____

Patient Demographics

Name: ____ DOB: ___/___/___

Last First M.I.

Home Address: ____ Email: __________________________

Street Apt # City State Zip

Best Contact Phone Number: ___________________ Secondary Phone Number: ______________________

Emergency Contact: Name__________________________Relationship:________________________

Contact Phone Number: __________________________