UNIVERSITY of MARYLAND
COMMUNITY MEDICAL GROUP

REGISTRATION FORM

Please Print Clearly

Date Completed:_____ ***Form Completed By:***_____

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ Middle: _____

Alias/ Nickname: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: ____

Permanent / Physical Address (Required) – *If PO Box is used for mailing please list as Confidential Address*

Street Address:_____

City: _____ State:_____ Zip Code:_____ County:_____

Temporary Address ☐ **Confidential Address** ☐ (Not Required) Start Date:_____ End Date: _____

Address: _____

City: _____ State:_____ Zip Code:_____ County:_____

Contact Phone Numbers: Home: _____ Work: _____

Cell / Mobile: _____ Email: _____

GENERAL INFORMATION

Interpreter Needed? Yes ☐ **No** ☐ Preferred Language: _____

Marital Status: _____ Spouse's Name: _____

Religion: _____

Hispanic / Latino Ethnicity? Yes ☐ NO ☐ Country of Birth: _____

Check all Race Categories the patient self-identifies as:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White / Caucasian
- ☐ Declined to Answer

REFERRING PHYSICIAN

Name: _____ Phone Number: _____

Location: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: _____

Location: _____

Approximate start date of care:_____

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EMPLOYMENT STATUS (Please Check One)

Employed: Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐

Occupation: _____ Employer: _____

Address: _____

Student : Full Time ☐ Part Time ☐

Retired: ☐ (Date) _____ Company:_____

Disabled: ☐ (Date) _____

EMERGENCY CONTACTS

Contact #1 Name: _____ Relationship: _____

Home: _____ Work: _____ Cell / Mobile: _____

Contact #2 Name: _____ Relationship: _____

Home: _____ Work: _____ Cell / Mobile: _____

GUARANTOR OF ACCOUNT (required if patient is a minor)

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other_____

Last Name: _____ First Name: _____ Middle: _____

Alias/ Nickname: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: ____

Billing Address: _____

City: _____ State:_____ Zip Code:_____ County:_____

INSURANCE INFORMATION

Primary Insurance:_____

Subscriber's Name:_____ Relationship to Patient:_____

Date of Birth:_____ SS#_____ Employer:_____

Patient Policy #: _____ Subscriber Policy #: _____

Group # (if applicable) _____

Secondary Insurance:_____

Subscriber's Name:_____ Relationship to Patient:_____

Date of Birth:_____ SS#_____ Employer:_____

Patient Policy #: _____ Subscriber Policy #: _____

Group # (if applicable) _____

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Consent Form

Patient Name: _____ **Date of Birth:** _____ **Date:**_____

FINANCIAL AGREEMENT: I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance, and items considered "not medically necessary" by my insurance company. I agree to pay co-payments and coinsurances as services are rendered. I understand my insurance is a contract between myself and my insurance company and the University of Maryland Community Medical Group Inc. (herein UMCMG Inc.) will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization is required by my insurance company, I will assist UMCMG Inc. in obtaining the referral and/or preauthorization. If payment cannot be made at each visit I will notify the front-desk staff to make other arrangements. I understand that I am ultimately responsible for any balance on my account. I certify that the information provided to UMCMG Inc. is accurate and up-to-date. Current insurance information must be on file at each visit for claims to be submitted appropriately. If new insurance information is provided after services are rendered I may be responsible for the account balance. If all attempts to collect reasonable amounts due fail and this account has been referred to a collection agency for action, I agree to pay all costs associated with the process allowed by law.

ASSIGNMENT OF BENEFITS: I hereby assign UMCMG Inc. such benefits to which are entitled under my insurance plan(s).

RELEASE OF INFORMATION: I hereby allow UMCMG Inc. to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, or other providers of service as necessary to obtain payment for services and provide additional care.

CONSENT FOR TREATMENT: I hereby allow UMCMG Inc. to examine, treat, and perform diagnostic tests and office procedures that the physician deems necessary.

PRIVACY PRACTICES: UMCMG Inc. is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must notify us in writing of any restrictions on the release of your protected health information. I have read and agree to the above. My signature below indicates that I have also received a copy of the UMCMG Inc. Notice of Privacy Practices and I have indicated any restrictions of my protected health information. Scanned signatures suffice as originals.

APPOINTMENT REMINDERS: If any telephone contact information I have provided is a mobile phone number, I hereby expressly consent to the placing of auto-dialed or prerecorded health care related calls to such number(s).

The undersigned certifies that he/she has read the foregoing and is the patient or the parent or guardian of the patient or is duly authorized as patient's agent to execute the above and accept its terms. By signing below, I represent that the information given by me to UMCMG Inc. is accurate to the best of my knowledge.

_____ _____

Patient or Responsible Party Signature **Date**

_____ _____

Patient / Responsible Party Name **Relationship to Patient**

_____ _____

Witness Signature **Witness Name**

UNIVERSITY of MARYLAND
COMMUNITY MEDICAL GROUP

MRN:

Patient Name:

UM Community Medical Group
Acknowledgment of Self–Pay Status
Patient Responsibility

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your doctor visit today be billed as "self-pay" and that you receive a "self-pay discount." A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and who will not be submitting the claim to an insurance carrier. You have requested that this service be billed as self-pay because (initial one):

_____ **You have no health insurance.**

_____ **You have health insurance but you do not want your insurance billed and instead want to pay out of pocket.**

_____ **Other (please explain):** _____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay service must be paid on the date of service.
- The self-pay amount covers only the professional services provided by your physician. You are financially responsible for all ancillary services, for example laboratory, x-ray or other services at UMCMG not performed by your physician. You will receive a separate bill from the UMMS Hospital Billing Department for those non-physician services.
- Please let your physician or a staff member know if you prefer to have your lab work or x-rays done by a non-UMMS facility. We will gladly provide you the paperwork you will need to accomplish this.

  Please Note: If you choose to use a non-UMMS facility it will be your responsibility to obtain your test results and provide the results to your physician
- If you have insurance or other types of coverage, services received today that are included in the "self-pay" discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient or Representative Signature _____ **Date** _____ **Time** _____

If signed by someone other than the patient, please specify relationship to the patient**:** _____

Interpreter Signature _____ **ID #** _____ **Date** _____ **Time** _____

NOT PART OF THE LEGAL MEDICAL RECORD

Past Medical History

Active Medical Problems: These are problems for which you are currently taking medication or are seeing another physician, such as high blood pressure, heart problems, ect. ☐ Check here if none.

_____

_____

Past Medical Problems: Have you ever been treated for, or taken medications for any of the following?

Anxiety	☐ Yes	☐ No
Hypertension (high blood pressure)	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Osteopenia (mild weakening of the bones) or Osteoporosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Abnormal Uterine Bleeding	☐ Yes	☐ No
Cancer: _____	☐ Yes	☐ No
Urinary Incontinence	☐ Yes	☐ No

Past Surgical History: Please include dates

☐ None

_____

_____

_____ Cholecystectomy _____ Appendectomy _____ Colonoscopy

Patient Name: _____ DOB: _____

Medication Names & Dosage

1. _____
2. _____
3. _____
4. _____
5. _____

If you have more medications than space allows, please write on back of this sheet.

Allergies to Medications : ☐ No known drug allergies

_____

_____

_____

Do you have an allergy to latex? ☐ Yes ☐ No ☐ Unknown

What are we seeing you for today? _____

Are you having any pain? _____ If so, where? _____

Pregnancy History

_____ Never Pregnant

_____ # of Pregnancies _____ # of live births _____# full term _____ # Premature

_____ # C-Sections _____ # Abortions _____ # Miscarriages

Did you breastfeed? _____ How many months did you breastfeed in your lifetime? _____

Breast Cancer Risk Assessment

Have you ever had a breast biopsy? _____ Have you ever had breast cancer? _____

Were you ever told that you had atypical hyperplasia or ductal carcinoma in situ? _____

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Consent Form

Patient Name: _____ **Date of Birth:** _____ **Date:**_____

Authorization to Disclose Health Information

I, _____**,** grant permission for the following person(s) to obtain information regarding medical care, speak with the provider, and/or staff and pick up any information regarding the patient listed above.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient or Responsible Party Signature **Date**

_____ _____
Patient / Responsible Party Name **Relationship to Patient**

Shore Women's Health
508 Idlewild Ave, Suite #4
Easton, Maryland 21601
Aisha Siddiqui, MD FACOG
Barbara Keirns, MD FACOG
Michell Jordan, CNM
Brittany Krautheim, CNM
Rebecca Ailstock, CNM

REQUEST FOR MEDICAL RECORDS

1. **I authorize (Name of Provider)_____**

   Name/Facility: **Shore Women's Health**
   508 Idlewild Ave, Suite #4
   Easton, MD 21601
   Phone: 410-820-4888 Fax: 410-822-7149

2. **Information from the medical records of:**

   Patients Name: _____

   Birth Date and/or Social Security No.: _____

   Dates of Treatment: _____ Phone No.: _____

3. **Information to be released: _____ ALL MEDICAL RECORDS(checks)**

4. **Purpose of disclosure:**

   _____ Medical Care _____ Personal Information _____ Insurance

   _____ Other _____

5. **I give special permission to release any information regarding: (Initial on lines below that apply)**

   _____ Substance Abuse _____Psychiatric/Mental Health Information

   _____ HIV Information

6. **This authorization will automatically expire one year from the date signed, except for criminal justice referrals and nursing home residents. I understand that I may revoke (In writing) this consent at any time except to the extent that action had been taken in reliance thereon. A photocopy of facsimile copy of this authorization shall constitute a valid authorization.**

Signed: _____ Date: _____
(If not patient, state relationship)

Witness: _____

Date completed: _____ Completed by: _____

Disclosure consisted of: _____