Arundel Medical Group Inc.

Welcome to Arundel Medical Group Inc.

Please place a check beside the reason for your visit.

_____ Medical

_____ Auto Accident (PIP)

_____ Workman's Comp

_____ FAA Physical

_____ Immigration Physical

_____ Weight Loss Program

_____ Chiropractic / Physical therapy

Signature:_____

Date:_____

PATIENT DETAIL SHEET

(PLEASE BE SURE TO COMPLETE ALL OF THE RED AREAS)

Please note that all spaces need to be filled in before returning to the front desk.

Thank You

LAST NAME: _____

FIRST NAME: _____

MIDDLE INITIAL: _____

ADDRESS: _____

CITY: _____

STATE: _____ **ZIP CODE:** _____

EMAIL ADDRESS: _____

ILLNESS DATE: _____ /_____ /_____

PHYSICIAN BEING SEEN: _____

REFERRING PHYSICIAN: _____

DATE	/ /

SEX: ☐ MALE ☐ FEMALE	**BIRTH DATE** / /
HOME PHONE #	**CELL PHONE #**
SOCIAL SECURITY #	– –
ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO	
LANGUAGE	**RACE** / **OFFICE USE ONLY** ☐ RTA

EMERGENCY CONTACT	**RESPONSIBLE PARTY/GUARDIAN**
NAME:	**NAME:**
PHONE #:	**PHONE #:**

PRIMARY INSURANCE COVERAGE *(COPY OF CARD MUST ACCOMPANY FORM!)*

INSURANCE CO. NAME: _____

POLICY HOLDER NAME: _____

POLICY HOLDER'S BIRTH DATE (If different from patient): _____ /_____ /_____

RELATIONSHIP TO PATIENT: _____

POLICY#: _____ **GROUP #:** _____

EMPLOYER: _____ **EMPLOYER PHONE #:** _____

SECONDARY INSURANCE COVERAGE *(COPY OF CARD MUST ACCOMPANY FORM!)*

INSURANCE CO. NAME: _____

POLICY HOLDER NAME: _____

POLICY HOLDER'S BIRTH DATE (If different from patient): _____ /_____ /_____

RELATIONSHIP TO PATIENT: _____

POLICY #: _____ **GROUP #;** _____

EMPLOYER: _____

VERIFIED BY:

Staff Initials

PATIENT'S AUTHORIZATION

I authorize ARUNDEL MEDICAL GROUP, INC. to apply for benefits on my behalf for services rendered by ARUNDEL MEDICAL GROUP. I request payment from my insurance company be made directly to ARUNDEL MEDICAL GROUP, INC. I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. If the account is turned over for collection, I agree to pay for any collection and attorney's fees.

_____ _____

Signature of Subscriber or Guarantor **Date**

Arundel Medical Group, Inc.

Medical History & Preventive Health Questionnaire

Name: _____ Birth Date: _____

PLEASE LIST **ANY** DISEASES YOU NOW HAVE OR HAVE HAD IN THE PAST.
(example ; high blood pressure, pneumonia, diabetes, thyroid disease, etc.) NONE____

1) _____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

PLEASE LIST **ANY** ALLERGIES YOU HAVE (medicines and environmental) NONE____
_____
_____

SMOKER? NO____ YES____ number of packs per day____for____years
ALCOHOL? NO____ YES____How much? _____
DRUGS? NO____ YES____ How much? _____
SEAT BELTS? NO____ YES____ Always____ Mostly____ Occasionally____

IN THE SPACE NEXT TO EACH SCREENING TEST OR TYPE OF COUNSELING, PLEASE MARK THE APPROXIMATE YEAR IN WHICH YOU LAST HAD IT DONE. IF NEVER, LEAVE IT BLANK, IF IT IS SOMETHING YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR TODAY, PLEASE CIRCLE IT.

____Vision and/or glaucoma testing ____Hearing test ____Last Dental appointment
____Skin care counseling (sunscreen usage/melanoma detection) ____Blood count
____Diabetes/cholesterol screening ____Thyroid screening ____HIV test
____Colonoscopy ____Treadmill or stress test ____Sexually transmitted disease tests
____Tuberculosis test (TB or tine) ____Tetanus vaccination ____Measles vaccination
____Flu vaccination ____Pneumonia vaccination ____Hepatitis B vaccination
____Breast exam and mammogram ____Last gyn exam/PAP smear ____Urinalysis
____Lead screening ____Depression screening ____Nutritional counseling
____Exercise counseling ____Sexual counseling (birth control/pregnancy/diseases)
____Substance abuse counseling ____"Baby shots" (DPT/OPV, MMR, HIB, Hep B)
____Injury/accident prevention (use of seat belts/poison control)
____Advanced directives (How you wish to be cared for in the event you become terminally ill or injured and are unable to voice your wishes)

COMMENTS_____
_____
_____
_____

YOUR OCCUPATION: _____

(over, please)

Arundel Medical Group, Inc.

Medical History & Preventive Health Questionnaire

PLEASE LIST *ALL* THE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER-THE-COUNTER MEDICATIONS AND BIRTH CONTROL PILLS (include dose if known) NONE____

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

PLEASE CHECK ANY DISEASE THAT RUNS IN YOUR FAMILY NONE____

___ Heart disease (heart attacks/angina/heart failure)
___ High Blood pressure
___ Diabetes
___ High Cholesterol
___ Alcoholism/Drug abuse
___ Stroke
___ Skin Cancer
___ Lung Cancer
___ Breast Cancer
___ Colon Cancer
___ Obesity

Below, list any diseases in your family not mentioned:
_____
_____
_____
_____
_____

PLEASE LIST *ALL* THE OPERATIONS YOU HAVE EVER HAD WITH THE YEAR IT WAS PERFORMED. NONE____

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

Any problems with anesthesia? NO___ YES___ (Please describe)

PLEASE LIST *WHY* YOU WERE HOSPITALIZED FOR MEDICAL DISEASES AND YEAR (Pneumonia, heart problems, accidents, etc.) NEVER HOSPITALIZED_____

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

MARRIED___ SEPARATED___ SINGLE___ WIDOWED___ DIVORCED___

Vaccine Administration Record for Adults

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Patient name_____

Birthdate_____ Chart number_____

PRACTICE NAME AND ADDRESS
Arundel Medical Group, Inc.
7575 Ritchie Highway
Glen Burnie, MD 21061

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] and Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td) Give IM.[3]									
Hepatitis A[6] (e.g., HepA, HepA-HepB) Give IM.[3]									
Hepatitis B[6] (e.g., HepB, HepA-HepB) Give IM.[3]									
Human papillomavirus (HPV2, HPV4, HPV9) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give Subcut.[3]									
Varicella (VAR) Give Subcut.[3]									
Meningococcal ACWY (e.g., MenACWY [MCV4], MPSV4) Give MenACWY IM.[7] Give MPSV4 Subcut.[7]									
Meningococcal B (e.g., MenB) Give MenB IM.[7]									

▶ See page 2 to record influenza, pneumococcal, zoster, Hib, and other vaccines (e.g., travel vaccines).

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (Sanofi Pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac, Tenivac (Sanofi Pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4, HPV5	Gardasil, Gardasil 9 (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
MPSV4	Menomune (Sanofi Pasteur)
MenB	Bexsero (GSK); Trumenba (Pfizer)

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p2023.pdf • Item #P2023 (4/16)

Vaccine Administration Record for Adults (continued)

Patient name_____

Birthdate_____ Chart number_____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

PRACTICE NAME AND ADDRESS
Arundel Medical Group, Inc.
7575 Ritchie Highway
Glen Burnie, MD 21061

Vaccine	Type of Vaccine[1]	Date vaccine given (mo/day/yr)	Funding Source (F,S,P)[2]	Route[3] and Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials and title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Influenza (e.g., IIV3, IIV4, ccIIV3, RIV3, LAIV4) Give IIV3, IIV4, ccIIV3, and RIV3 IM.[3] Give LAIV4 NAS.[3]									
Pneumococcal conjugate (e.g., PCV13) Give PCV13 IM.[3]									
Pneumococcal polysaccharide (e.g., PPSV23) Give PPSV23 IM or Subcut.[3]									
Zoster (HZV) Give Subcut.[3]									
Hib Give IM.[3]									
Other									

▶ See page 1 to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, MenACWY, and MenB vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
IIV3 (inactivated influenza vaccine, trivalent); IIV4 (inactivated influenza vaccine, quadrivalent); ccIIV3 (cell culture-based inactivated influenza vaccine, trivalent); RIV3 (inactivated recombinant influenza vaccine, trivalent)	Fluarix (GSK); Flublok (Protein Sciences Corp.); Afluria, Fluad, Flucelvax, Fluvirin (Seqirus); FluLaval (GSK); Fluzone, Fluzone Intradermal, Fluzone High-Dose (Sanofi Pasteur)
LAIV (live attenuated influenza vaccine, quadrivalent)	FluMist (MedImmune)
PCV13	Prevnar 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
HZV (shingles)	Zostavax (Merck)
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHib (Merck)

ARUNDEL MEDICAL GROUP, INC.

(A corporation in service to your physician.)

PATIENT CONSENT

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to THE ARUNDEL MEDICAL GROUP, INC. (a corporation in service to your physician) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may request a copy of the revised notice. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION (if applicable):
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare or Medicaid claim.

_____
Print Patient's Name

_____
Patient's or Guardian's Signature

_____
Other Than Patient, Print Name & Relationship/Guardianship

_____
Witness

ARUNDEL MEDICAL GROUP, INC.

(A corporation in service to your physician.)

PATIENT'S AUTHORIZATION

I authorize the ARUNDEL MEDICAL GROUP, INC. (a corporation servicing my physician) to release by mail, fax, electronic transmission or by phone protected health information for the purpose of treatment and required healthcare operations to (but not exclusive to) another physician's/physicians' office(s), healthcare facility, hospital, surgery center, laboratory, radiology facility and pharmacy.

I understand that I must fully complete and sign separate authorization forms for each request for release of copies of medical records, for each personal injury protection (automobile accident), claim, for each workman's compensation claim, for each disability request for medical information, for each life insurance request for medical information and/or for any request for the release of protected health information not previously listed.

I authorize ARUNDEL MEDICAL GROUP, INC. to apply for benefits on my behalf for services rendered by ARUNDEL MEDICAL GROUP, INC. I request payment from my insurance company be made directly to ARUNDEL MEDICAL GROUP, INC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

_____ _____

Print Patient's Name Date

_____ _____

Patient's or Guardian's Signature Witness

_____

Other Than Patient (Print Name & Relationship/Guardianship)