Account #: _____

Mid-Atlantic Surgical Group

Walker, Kerrigan, Chin, Wilhite, McCutcheon, Haberlin, Said-Mahmoudian, Kastello & Bounds, P.A.
6507 Deer Pointe Drive, Salisbury Maryland 21804
Telephone: 410-543-9332 Fax: 410-543-9237
www.mid-atlanticsurg.com

Patient Registration Form

Patient Name: (First)_____(M)_____(Last)_____

Social Security Number:_____-_____-_____ Date of Birth: _____/_____/_____Age:_____

Sex:_____ Race:_____ Marital Status:_____

Address: _____

_____

Home Phone:(_____)-_____-_____ Cell Phone:(_____)-_____-_____ Work Phone:(_____)-_____-_____

Email Address:_____ Advance directive or living will?: **YES / NO**

Primary Care Doctor:_____(P): (_____)-_____-_____

Referring Doctor:_____(P): (_____)-_____-_____

Emergency Contact

Name: (First)_____(Last)_____ Relationship:_____ P: (_____)-_____-_____

Address: _____

Primary Insurance Information

Name:_____ I.D. Number:_____

Address:_____ Group Number: _____

Policy Holder:_____ Effective Date: _____/_____/_____

Policy Holder SSN:_____-_____-_____ Policy Holder DOB: _____/_____/_____

Secondary Insurance Information

Name:_____ I.D. Number: _____

Address:_____ Group Number: _____

Policy Holder:_____ Effective Date: _____/_____/_____

Policy Holder SSN:_____-_____-_____ Policy Holder DOB: _____/_____/_____

Employment Status:_____ Employer: _____
Address:_____ (P) (_____)-_____-_____

I attest that the above information is truthful to the best of my knowledge and certify so by the signing of my name.

Patient Signature:_____ Date:_____/_____/_____

Account #: _____

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Medicare Questionnaire

Patient Name: (First)_____(M)_____(Last)_____

1). Are you entitled to Medicare based on:

_____ Age

_____ Disability

_____ End Stage Renal/Kidney Disease (ESRD)

2). Are you currently employed? Is your spouse currently employed?

_____ Yes _____ Yes

_____ No _____ No

3). Do you have other health insurance through either you or your spouse's employer? Please be sure to provide us with that information.

_____ Yes

_____ No

4). Have you made any changes to your Medicare Plan?

_____ Yes

_____ No

5). If you have joined a Medicare Advantage Plan (Medicare Part C) PLEASE be sure to provide us this information. Do you have any other insurance card through a "Medicare" plan other than your red, white, and blue Medicare card?

_____ Yes

_____ No

6). Is your Medicare Advantage plan an HMO, PPO, or PFFS (Private Fee For Service Plan)?

_____ HMO (HMO plans require you to have a referral to be treated)

_____ PPO

_____ PFFS

*****If you have ANY other insurance in place of Medicare or Secondary/Primary to your Medicare Plan please provide the front desk with that information, this includes Medicare Advantage Plans as well as Supplement Plans etc. PRIOR to being seen to avoid any extra expenses*****

I attest that the above information is truthful to the best of my knowledge and certify so by the signing of my name.

Patient Signature:_____ Date:_____/_____/_____

Account #: _____

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I, _____(Print Name), hereby authorize release of any medical information to all other doctors associated with my healthcare.

I hereby authorize release of any medical or any other necessary information that is needed to process my claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment below.

I hereby authorize payment of medical benefits to the rendering physician or supplier for services described below.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my insurance status or demographic information.

I also acknowledge, understand, and agree that if my account becomes delinquent and sent to an attorney for the initiation of collection procedures, that in addition to the actual amount of the bill, I will be responsible for the reasonable attorney's fees construed to be thirty-three and one-third percent (33 1/3%) of the outstanding amount as well as interest on my account computed at eighteen percent (18%) per annum for those balances exceeding thirty (30) days.

Jurisdiction and Venue: If any must be filed to collect an unpaid balance on an account, patient and/or guarantor, agrees that such suit may be brought in to courts of Wicomico County, Maryland, and waives any objection to jurisdiction or Venue.

I attest that I have read and understand the above information and certify so by the signing of my name.

Patient Signature:_____ Date:_____/_____/_____
Or Authorized Person's Signature

Medigap Authorization and Assignment:

Patient Signature:_____ Date:_____/_____/_____
Or Authorized Person's Signature

Account #: _____

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General Authorization to Release Information

I, _____(Print Name), hereby authorize release of information necessary for my diagnosis and treatment from any medical doctors or facilities that have treated me in the past to the providers of Mid-Atlantic Surgical Group, (i.e. Drs. Walker, Kerrigan, Chin, Wilhite, McCutcheon, Haberlin, Said-Mahmoudian, Kastello, and Bounds). This would include but not be limited to previous surgeries, medications, and complete medical history.

Patient Signature:_____Date:_____/_____/_____
Or Authorized Person's Signature

Patient Social Security Number: _____-_____-_____

I DO grant _____ / DO NOT grant _____ my permission for my prescription history to be viewed from external sources and pharmacies.

Patient Signature:_____Date:_____/_____/_____
Or Authorized Person's Signature

I attest that the above information is truthful to the best of my knowledge and certify so by the signing of my name.

Account #: _____

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Patient Portal Access

Our patient portal will email you appointment reminders and will give you access to your office notes.

If you would like to sign up for our patient portal, please provide the following:

Patient Name: _____

Email Address: _____

You will receive an email with your Username, Password, and the link to that will take you to your patient portal.

Patient Signature:_____Date:_____/_____/_____
Or Authorized Person's Signature

If you DO NOT wish to sign up for a patient portal please sign below:

Patient Signature:_____Date:_____/_____/_____
Or Authorized Person's Signature

I attest that the above information is truthful to the best of my knowledge and certify so by the signing of my name.

Account #: _____

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Name: _____ **Date:** _____/_____/_____

Reason for Today's Visit: _____

_____

_____

Current Medications:

Name	Dosage	How often do you take?

Allergies:	What Kind of Reaction?	Any Significant Medical Condition?
1		1
2		2
3		3
4		4
5		5

Have you had any Previous Surgeries? If so please list the surgery you had as well as when you had it.

1_____

2_____

3_____

4_____

5_____

Do you have a cardiologist, if so, who is it? _____

Have you ever had MRSA? No ( ) Yes ( ) , if so, When? _____**, Where?** _____

Do you have a Latex allergy? _____

For Internal Use Only: Height: _____ Weight:_____

NAME_____ S.S.#_____ DATE:_____

WHAT IS YOUR PRESENT PROBLEM?

_____

_____

ARE YOU ALLERGIC TO ANY DRUGS OR MEDICINES? NO_____ YES_____

1._____

2._____

3._____

ARE YOU TAKING ANY MEDICINES AT PRESENT? NO_____ YES_____

1._____ DOSAGE _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

7._____ _____

8._____ _____

SOCIAL HISTORY

Do you use Tobacco? NO____ YES____ HOW MUCH?_____

Do you use Alcohol? NO____ YES____ HOW MUCH?_____

Do you use drugs? NO____ YES____ HOW MUCH?_____

FAMILY HISTORY

Is there any history in your family of the following?

CANCER NO____ YES____ WHOM_____

TB NO____ YES____ WHOM_____

HEART DISEASE NO____ YES____ WHOM_____

STROKE NO____ YES____ WHOM_____

HIGH BLOOD NO____ YES____ WHOM_____

DIABETES NO____ YES____ WHOM_____

WOMEN ONLY:

Age at onset of menstrual period____. Age at 1st live birth____. Age of Menopause (Natural/Surgical)_____.

Number of pregnancies____. Number of live births____. Breast feeding____.

HORMONES/BIRTH CONTROL NO____ YES____ HOW MANY YEARS?____ WHEN DID YOU STOP?_____

HYSTERECTOMY ? NO____ YES____

OVARIES REMOVED? NO____ YES____

DO YOU HAVE ANY OF THE FOLLOWING? (check all that apply)

YES	NO		YES	NO	
○	○	Irregular heart beat or rhythm	○	○	Skin lesions or rashes
○	○	Pain in chest	○	○	Frequent urination
○	○	Shortness of breath	○	○	Trouble urinating
○	○	Chronic cough	○	○	Leaking of urine
○	○	Cough blood	○	○	Blood in Urine
○	○	Cough sputum	○	○	Pus in urine
○	○	Wheezing	○	○	Air in urine
○	○	Hoarseness or sore throat	○	○	Burning on urination
○	○	Ankle swelling	○	○	Get up at night to urinate
○	○	Calf or leg pain when walking	○	○	Abdominal swelling
○	○	Fever or chills	○	○	Loss of appetite
○	○	Severe dizziness	○	○	Trouble swallowing
○	○	Severe headaches	○	○	Frequent indigestion
○	○	Severe weakness	○	○	Abdominal pain
○	○	Severe numbness	○	○	Nausea
○	○	Unsteady gait	○	○	Vomiting
○	○	Ringing in ears or deafness	○	○	Trouble eating fat/fried food
○	○	Blurred vision or blindness	○	○	Frequent constipation
○	○	Severe joint pain or swelling	○	○	Dark stools
○	○	Frequent severe back pain	○	○	Liquid stools
○	○	Weight loss or gain	○	○	Blood in stools
○	○	Lumps or masses	○	○	White or yellow stools

PAST MEDICAL HISTORY (Check all that apply)

YES	NO		YES	NO		YES	NO	
○	○	High blood pressure	○	○	Kidney disease	○	○	Cancer
○	○	Heart attack/Angina	○	○	Hepatitis/Liver disease	○	○	Thyroid disease
○	○	Heart failure	○	○	Asthma/COPD	○	○	Arthritis/Osteoporosis
○	○	Heart valve disease	○	○	TB/Other lung disease	○	○	Depression/Anxiety
○	○	High cholesterol	○	○	Blood clots(DVT or PE)	○	○	Other Psychiatric problems
○	○	Peripheral vascular disease	○	○	Other blood diseases	○	○	Alzheimer's disease
○	○	Stroke	○	○	History of blood transfusion	○	○	HIV/AIDS
○	○	Seizures	○	○	Inflammatory Bowel Disease	○	○	Anesthesia problems
○	○	History of radiation treatment	○	○	Peptic Ulcer/Gastric Reflux	○	○	Connective Tissue Diseases
○	○	Diabetes	○	○	Sleep Apnea/CPAP			

Any other medical conditions: _____

HAVE YOU EVER HAD ANY OPERATIONS? **YEAR?**

_____

_____

_____

_____

_____

_____

HAVE YOU EVER HAD ANY HOSPITALIZATIONS? (OTHER THAN SURGERY)

_____

_____

DATE OF LAST COLONOSCOPY: _____

REVIEWED BY: _____

Mid-Atlantic Surgical Group

General/Constitutional

Fever	O Yes	O No
Chills	O Yes	O No

Cardiovascular

Irregular heart beat	O Yes	O No
Murmurs	O Yes	O No
Chest pain	O Yes	O No

Respiratory

Persistent cough	O Yes	O No
Blood-tinged sputum	O Yes	O No
Shortness of breath	O Yes	O No

Cardiovascular

Pains in leg while walking	O Yes	O No
Leg edema	O Yes	O No

Gastrointestinal

Loss of appetite	O Yes	O No
Weight loss	O Yes	O No
Acid reflux	O Yes	O No
Blood in stool	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Difficulty urinating	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Anemia	O Yes	O No

Neurologic

Headache	O Yes	O No

Cardiovascular

Dizziness	O Yes	O No

Neurologic

Confusion	O Yes	O No

Musculoskeletal

Back pain	O Yes	O No
Arthritis	O Yes	O No

Endocrine

Fatigue	O Yes	O No
Thyroid disorder	O Yes	O No

Skin

Suspicious moles	O Yes	O No
Suspicous lesions	O Yes	O No