



Western Maryland Medical Arts Center, 12502 Willowbrook Road, Suite 460 • Cumberland, MD • 21502 • (240) 964-8931

MR# \_\_\_\_\_

|  |  |  |         |  |  |   |  |  |
|--|--|--|---------|--|--|---|--|--|
| Patient Name: Last   |  |  | First   |  |  | Middle  |  |  |
| Date of Birth / /  |  |  | Age     |  |  | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |  |  |
| Social Security Number (SS #)  |  |  |         |  |  |   |  |  |
| Street Address   |  |  |         |  |  |   |  |  |
| City   |  |  | State   |  |  | Zip   |  |  |
| Email Address  |  |  |         |  |  |   |  |  |
| Would you like to receive emails regarding periodic special offers and news from our practice? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |         |  |  |   |  |  |
| Home Phone   |  |  | Mobile  |  |  | Work  |  |  |
| Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed  |  |  |         |  |  |   |  |  |
| Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Unreported/Refused to Report <input type="checkbox"/> Undefined |  |  |         |  |  |   |  |  |
| Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unreported <input type="checkbox"/> Refused to Report <input type="checkbox"/> Undefined                            |  |  |         |  |  |   |  |  |
| Language Preference  |  |  |         |  |  |   |  |  |
| Employer   |  |  |         |  |  |   |  |  |
| Spouse's Name  |  |  | DOB / / |  |  | SS #  |  |  |
| Spouse's Employer  |  |  |         |  |  | Work Phone  |  |  |
| Emergency Contact  |  |  |         |  |  | Relationship  |  |  |
| Emergency Contact Number   |  |  |         |  |  |   |  |  |

**DISCLOSURE OF PROTECTED HEALTH INFORMATION**

According to office policy, test results or release of medical information including, but not limited to, appointment times, lab or test results, etc., will be provided to the patient only. Please specify below whom information may be released to other than yourself.

I grant permission for WMHS Plastic Surgery to release any and all of my medical information to the person(s) listed below.

Patient Signature: \_\_\_\_\_

|      |              |      |              |
|------|--------------|------|--------------|
| Name | Relationship | Name | Relationship |
|      |              |      |              |
| Name | Relationship | Name | Relationship |
|      |              |      |              |

May we leave messages at your:  Home Answering Machine  Cell Phone  Work Voice Mail  Email

**FINANCIAL INFORMATION**

|  |  |        |                         |      |  |
|--|--|--------|-------------------------|------|--|
| Person Responsible for Payment           |  |        | Relationship to Patient |      |  |
| Street Address (if different from above) |  |        |                         |      |  |
| City                                     |  | State  |                         | Zip  |  |
| Home Phone                               |  | Mobile |                         | Work |  |

**IF THE PATIENT IS A MINOR/STUDENT**

|                                     |       |          |                                     |             |     |
|-------------------------------------|-------|----------|-------------------------------------|-------------|-----|
| Father's Name/Legal Guardian        |       |          | Mother's Name/Legal Guardian        |             |     |
| Address (if different from patient) |       |          | Address (if different from patient) |             |     |
| City                                | State | Zip      | City                                | State       | Zip |
| SS #                                | DOB   | / /      | SS #                                | DOB         | / / |
| Home/Cell #                         |       | Work#    |                                     | Home/Cell # |     |
| Employer                            |       | Employer |                                     | Employer    |     |



Western Maryland Medical Arts Center, 12502 Willowbrook Road, Suite 460 • Cumberland, MD • 21502 • (240) 964-8931

MR# \_\_\_\_\_

**PLEASE COMPLETE ALL SECTIONS**

|                                 |     |                   |     |
|---------------------------------|-----|-------------------|-----|
| <b>Primary Insurance Name</b>   |     | Subscriber's Name |     |
| Relationship to Patient         | DOB | / /               | SS# |
| <b>Secondary Insurance Name</b> |     | Subscriber's Name |     |
| Relationship to Patient         | DOB | / /               | SS# |

Eligible for coverage under Workers' Compensation/Job Related?  Yes  No

Is your injury/illness due to an accident?  Yes  No  Automobile  Other (describe below)

---

Date of accident/injury      /      /      State where accident/injury occurred:

**COMPLETE THIS SECTION IF YOU ARE COVERED UNDER MEDICARE**

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions.

|  |   |
|--|---|
| Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If retired, list date of retirement      /      /<br>Please list employer information on front of form.<br>Please complete health plan information on front of form. | Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If retired, list date of retirement      /      /<br>Please list employer information on front of form.<br>Please complete health plan information on front of form. |
|--|---|

**ADVANCED DIRECTIVES**

Do you have a Living Will or Durable Power of Attorney?  Yes  No

Please provide WMHS Plastic Surgery with a copy of your file. WMHS Plastic Surgery does not honor Advanced Directives/Living Wills and our policy is as follows: Regardless of any advanced directive, if an adverse event occurs during your treatment at this office, we will initiate resuscitative or other stabilizing measures and transfer you to the nearest hospital for further evaluation. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this policy by your signature does not revoke or invalidate any current health care power of attorney.

**AUTHORIZATION**

I authorize WMHS Plastic Surgery to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Centers for Medicare & Medicaid Services, Third Party Administrators, and/or Workers Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize WMHS Plastic Surgery to utilize a fax machine or secure email to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing or secure emailing of my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to WMHS Plastic Surgery to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians and outpatient facilities. I request that payment of Medicare, Third Party Administrators for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between WMHS Plastic Surgery and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

\_\_\_\_\_  
Signature of Patient or Responsible Party/Insured

\_\_\_\_\_  
Date



Office Use Only

Dr. # \_\_\_\_\_

MR# \_\_\_\_\_

Acct. # \_\_\_\_\_

B/P \_\_\_\_\_ / \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Patient Name

Last

First

Middle

Date of Birth

Age

Referred By \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Reason for appointment \_\_\_\_\_

If applicable: date of injury or onset of problem \_\_\_\_\_

Is this the result of a work or car accident?  Yes  No

What makes the problem/pain worse or better? \_\_\_\_\_

**Past Medical History**

Have you ever been a patient in this office?  Yes  No

**IF ADDITIONAL SPACE IS NEEDED IN ANY SECTION OF THIS FORM ATTACH A SEPARATE SHEET**

List any current medical problems you have.

Medical Problem

Medical Problem

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |

**Allergies:** List medications and/or foods that you are allergic to and what kind of reaction you have.

Medication/Food

Reaction

Medication/Food

Reaction

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Family History:** Any family history of medical problems? If so, please list.

Type of Problem

Family Member

Type of Problem

Family Member

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Social History**

Student:  Yes  No Grade Level \_\_\_\_\_  Full time  Part time

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

How Long? \_\_\_\_\_

Marital Status  Married  Single  Divorced  Separated  Widowed

Use of Alcohol  Never  Rarely  Moderate (2 drinks/day)  Heavy (more than 2 drinks/day)

Tobacco Use  Never  Smoker \_\_\_\_\_ Packs/day  Previous Smoker: Date quit \_\_\_/\_\_\_/\_\_\_  Chew Tobacco  Use Snuff

Drug Use  Never  Yes Type: \_\_\_\_\_

Dominant hand  Left  Right If you have children ages 0-17 list their ages: \_\_\_\_\_

**Present Medications:** Prescriptions or non-prescription

Name of Medication

Dosage/Frequency

Name of Medication

Dosage/Frequency

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever had any problem with anesthesia?  Yes  No If yes, explain. \_\_\_\_\_

**Surgical/Hospitalization History**

Type of Surgery or Hospitalization

Date

Type of Surgery or Hospitalization

Date

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD A PROBLEM WITH:**

|  |   |  |   |  |  |   |
|--|---|--|---|--|--|---|
| <p><b>Breast</b></p> <input type="checkbox"/> Breast Discharge<br><input type="checkbox"/> Breast Pain<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Fibrocystic Disease<br><input type="checkbox"/> Lump in Breast   | <p><b>Cancer</b></p> <input type="checkbox"/> Brain<br><input type="checkbox"/> Breast<br><input type="checkbox"/> Cervical<br><input type="checkbox"/> Colon<br><input type="checkbox"/> Ovarian<br><input type="checkbox"/> Prostate<br><input type="checkbox"/> Rectal<br><input type="checkbox"/> Skin<br><input type="checkbox"/> Stomach<br><input type="checkbox"/> Throat<br><input type="checkbox"/> Thyroid   | <p><b>Cardiac</b></p> <input type="checkbox"/> Angina Pectoris<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> Coronary Artery Disease<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Hypertension (High Blood Pressure)<br><input type="checkbox"/> Hypotension (Low Blood Pressure)<br><input type="checkbox"/> Irregular Heartbeat<br><input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> Swelling of Feet, Ankles or Hands<br><input type="checkbox"/> High Cholesterol | <p><b>Hematology</b></p> <input type="checkbox"/> Abnormal bleeding in your family<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Bleeding or Bruising Tendency<br><input type="checkbox"/> Clotting Disorder<br><input type="checkbox"/> Deep Venous Blood Clots<br><input type="checkbox"/> Known HIV/AIDS Exposure<br><input type="checkbox"/> Phlebitis<br><input type="checkbox"/> Slow to heal after cuts<br><input type="checkbox"/> Transfusion History | <p><b>Endocrine</b></p> <input type="checkbox"/> Diabetes Type I<br><input type="checkbox"/> Diabetes Type II<br><input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> Excessive Urination<br><input type="checkbox"/> Glandular Hormone<br><input type="checkbox"/> Heat or Cold Intolerant<br><input type="checkbox"/> Hyperthyroidism<br><input type="checkbox"/> Hypothyroidism  | <p><b>Gastrointestinal</b></p> <input type="checkbox"/> Abdominal Pain<br><input type="checkbox"/> Colon Polyps<br><input type="checkbox"/> Duodenal Ulcer<br><input type="checkbox"/> Gastric Ulcer<br><input type="checkbox"/> GERD<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hiatal Hernia<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Nausea & Vomiting<br><input type="checkbox"/> Ulcerative Colitis |   |
| <p><b>Genitourinary</b></p> <input type="checkbox"/> Hematuria<br><input type="checkbox"/> Incontinence<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Urinary Frequency<br><input type="checkbox"/> Urinary Tract Infections<br><input type="checkbox"/> Urinary Tract Problem  | <p><b>HEENT</b></p> <input type="checkbox"/> Allergic Rhinitis<br><input type="checkbox"/> Blurred/Double Vision<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Chronic Sinusitis<br><input type="checkbox"/> Ear Drainage<br><input type="checkbox"/> Ear Infections<br><input type="checkbox"/> Earache<br><input type="checkbox"/> Eye Disease<br><input type="checkbox"/> Eye Injury<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Head Injury<br><input type="checkbox"/> Hearing Loss<br><input type="checkbox"/> Mouth Sores<br><input type="checkbox"/> Nasal Polyps<br><input type="checkbox"/> Nose Bleeds<br><input type="checkbox"/> Ringing in Ears<br><input type="checkbox"/> Glasses/Contacts | <p><b>Congenital</b></p> <input type="checkbox"/> Cleft Lip<br><input type="checkbox"/> Cleft Palate<br><input type="checkbox"/> Facial Deformity<br><input type="checkbox"/> Hand Deformity<br><input type="checkbox"/> Skull Deformity   | <p><b>Respiratory</b></p> <input type="checkbox"/> Asthma<br><input type="checkbox"/> Chronic or Frequent Cough<br><input type="checkbox"/> COPD<br><input type="checkbox"/> Emphysema of Lung<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Sleep Apnea<br><input type="checkbox"/> Tuberculosis   | <p><b>Musculoskeletal</b></p> <input type="checkbox"/> Arthritis<br><input type="checkbox"/> Back Injury<br><input type="checkbox"/> Back Pain<br><input type="checkbox"/> Cold Extremities<br><input type="checkbox"/> Difficulty Walking<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Joint Injury<br><input type="checkbox"/> Joint Pain<br><input type="checkbox"/> Joint Problems<br><input type="checkbox"/> Joint Stiffness/Swelling<br><input type="checkbox"/> Low Back Pain<br><input type="checkbox"/> Muscle Pain/Cramps<br><input type="checkbox"/> Neck Pain<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Weakness<br><input type="checkbox"/> Weakness of muscles or joints | <p><b>Neurologic</b></p> <input type="checkbox"/> Head Injury<br><input type="checkbox"/> Migraine Headache<br><input type="checkbox"/> Numbness & Tingling<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Restless Leg Syndrome<br><input type="checkbox"/> Seizure Disorder<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Transient Ischemic Attack<br><input type="checkbox"/> Tremors  |   |
| <p><b>Psychiatric</b></p> <input type="checkbox"/> ADD<br><input type="checkbox"/> ADHD<br><input type="checkbox"/> Alcohol Abuse<br><input type="checkbox"/> Alzheimer's<br><input type="checkbox"/> Anxiety Disorder<br><input type="checkbox"/> Bipolar Disease<br><input type="checkbox"/> Confusion<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Drug Dependency<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Memory Loss<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Other |   |  |   |  |  | <p><b>Skin</b></p> <input type="checkbox"/> Change in Skin<br><input type="checkbox"/> Rash or Itching<br><input type="checkbox"/> Varicose Veins |

**PRESCRIPTION REFILL POLICY**

Refills for Prescription Medications need to be called in to our office between 8:30 am and 4:00 pm Monday through Friday. All approved prescriptions will be called into the pharmacy by the end of that business day. Prescriptions should be taken "AS DIRECTED." Early refills may be denied. No medications will be refilled after hours or on weekends.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**I have reviewed the above information with the patient.**

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date