



Patient Name

First Name

Middle Name

Last Name

Patient DOB

Please complete if there have been any changes:

Patient Occupation

Patient Employer

Primary Care MD Name/Number

Reason for Visit

Any New Medical Conditions

If none, please write "none"

Any New Surgical History

If none, please write "none"

Medications

If none, please write "none"

Preferred Pharmacy/Number

If you do not have number, please give an identifier of location

Any New Allergies

If none, please write "none"

Has there Been Any Change in Your Tobacco Use Status:

Smoker Status (Never, Former, Current Smoker)

Amount Per Day

Type

Years Using/Used

Quit Date (if applicable)

Quit Attempts

Second Hand Smoke Exposure

Height

(Feet and Inches)

Weight

(Pounds)

Patient Address

Address Line 1

Address Line 2

City

State / Province / Region

Postal / Zip Code

Email

Your email will only be used by our office for communicating with you

Patient Phone

Preferred Number

Alternate Number

Emergency Contact

First Name

Last Name

Phone Number

Relationship

**Greater Chesapeake Hand Specialists, PA
Authorization and Financial Responsibility**

I hereby authorize Greater Chesapeake Hand Specialists, PA to furnish information to insurance companies concerning my illness and treatment. I hereby irrevocably assign Greater Chesapeake Hand Specialists, PA all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered, or denied by my insurance company. A photocopy of this authorization shall be considered as effective and valid as an original. I also understand that if my workman's compensation claim has not yet been approved, Greater Chesapeake Hand Specialists, PA is required to file with my private insurance carrier.

I agree that Greater Chesapeake Hand Specialists, PA may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I authorize Greater Chesapeake Hand Specialists, PA to initiate a complaint to the insurance commissioner for any reason on my behalf.

I authorize Greater Chesapeake Hand Specialists, PA to transfer any overage balance owed to me to any outstanding payment balance due to Lutherville SurgiCenter, LLC on my behalf.

In the event that my account is referred to an attorney or collection agency, I agree to pay reasonable attorney fees and court costs and understand that additional collection fees of 20% may be added to my original debt owed. I further agree that all legal proceedings shall occur in Baltimore County, Maryland.

Signed at Greater Chesapeake Hand Specialists, PA

Signature

Date

If financially responsible/insurance person is other than patient/legal guardian please sign below

Signature

Date