HIRSH HEALTH CENTER Registration Form

Today's Date ____________________ Primary Care Provider (previous) ____________________

PATIENT INFORMATION

Last Name ____________________ First Name ____________________ MI ____ Mr. Mrs. Ms. Miss

Marital Status: Married Single Widowed Separated Divorced Birth Date ____________________ Age ________

Sex: M F Cisgender M Cisgender F Non-binary Non Cisgender

Mailing Address ____________________ City ____________________ State ______ Zip ________

Billing Address (if different from above) ____________________

Social Security # ____________________ Phone # ____________________ Email ____________________

Referred to Clinic By (please check one box):

Dr. ____________________ Insurance Plan Hospital Family Friend Close to Home/Work Other ________

INSURANCE INFORMATION *(Please show your insurance card to the receptionist)*

Medicare # ____________________ Part A Part B Other ________

Secondary Coverage ____________________ Group # ____________________ Policy # ____________________

Subscriber's Last Name ____________________ First Name ____________________ MI ____ Maiden Name ________

IN CASE OF EMERGENCY

Name ____________________ Relationship to Patient ____________________

Phone # ____________________ Email ____________________

Medical Power of Attorney: Yes No Spouse Other ____________________

Financial Power of Attorney: Yes No Spouse Other ____________________

POA Address ____________________

Responsible Party/Healthcare Surrogate (if other than patient): Name ____________________

Relationship ____________________ Contact Information ____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician practice. I understand that I am financially responsible for any balance. I also authorize Hirsh Health Center or insurance company to release any information required to process my claims. Medicare Patients Only: I understand that Medicare may deny payment for certain services and that I will be financially liable for these services. I will be informed in advance if there is a possibility that Medicare will not cover the service.

In the event I am unable to pay for my care due to physical or mental disability, the following individual is authorized to make payments on my behalf and has agreed to serve in that capacity.

Name ____________________ Contact Information ____________________

Signature of Patient/Responsible Party ____________________ **Date** ____________________

HIRSH HEALTH CENTER | 1801 EAST JEFFERSON STREET ROCKVILLE, MD 20852 | PHONE 301-816-5004 FAX 844-585-5549

HIRSH HEALTH CENTER Medical Records Request

Date ______________________________

Patient Name ____

Physician Name ____

Address ____

____

Phone # ______________________________ Fax # ______________________________

This is an authorization for my physician's practice to send my medical records to:

Hirsh Health Center
1801 East Jefferson St.
Rockville, MD 20852
P: (301) 816-5004
F: (844) 585-5549

NOTE: *Only if records are more than 20 pages, then please fax to (240) 283-6402.*

Signature ____

If signed by a person other than the patient, please indicate your relationship to the patient:

Relationship to Patient ____________________________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the
Charles E. Smith Life Communities HIPAA Notice of Privacy Practices.

Patient Name (please print) ______________________________ Date ________________

Patient Signature ____

If this Acknowledgment is being signed by a personal representative of the patient,
provide the information below:

Personal Representative's Name (please print) ______________________________________

Personal Representative's Signature ____

Relationship to Patient: Parent Guardian Power of Attorney Other________________

OFFICE USE ONLY *(If signature cannot be obtained)*

I tried to obtain written acknowledgment by the individual noted above of receipt of our
Notice of Privacy Practices, but it could not be obtained because:

An emergency prevented us from obtaining acknowledgement; or

A communication barrier prevented us from obtaining acknowledgement; or

The patient or representative was unwilling to sign; or

Other____

Team Member's Name (please print) ______________________________ Date ____________

Team Member's Signature ____

HIRSH HEALTH CENTER | 1801 EAST JEFFERSON STREET ROCKVILLE, MD 20852 | PHONE 301-816-5004 FAX 844-585-5549

HIRSH HEALTH CENTER Health Questionnaire

Name (Last, First, M.I.) ______________________________ Date ____________

Sex: M F Cisgender M Cisgender F Non-binary Non Cisgender DOB ____________

Previous or Referring Provider ______________________ Date of Last Physical Exam ________

PERSONAL HEALTH HISTORY

Immunizations and Dates: Tetanus (Tdap) ____________ Pneumonia (Prevnar-13) ____________

Hepatitis B ____________ Pneumonia (Pneumovax-23) ____________

Influenza ____________ Shingles (Varicella) ____________

Measles, Mumps, Rubella (MMR) ________________________

Covid-19 ____________ Manufacturer: ____________

____________ ____________

____________ ____________

List of Medical/Psychiatric Health Issues:

____

____

____

SURGERIES		
Year	Reason	Hospital

HOSPITALIZATIONS		
Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No When? ____________ Why? ____________

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LIST MEDICATIONS YOU ARE CURRENTLY TAKING *(including over-the-counter medications)*

Name of Medication	Dose (Strength of Medication)	Frequency Taken

ALLERGIES *(medications & others)*

Name of Medication	Reaction

Pharmacy ____________ Pharmacy Address ____________________ Pharmacy Phone # ____________

FAMILY HEALTH HISTORY

Adopted Unknown

	Age of Illness/Death	Significant Health Problems (Including Mental Health)
Father		
Mother		
Sibling(s)		
Sibling(s)		
Children		
Children		

HEALTH SCREENING		
Exercise	Sedentary (no exercise)	Mild exercise (climb stairs, walk 3 blocks, golf, etc.)
	Occasional vigorous exercise (less than 4x/week for 30 min.)	
	Regular vigorous exercise (4x/week for 30 min.)	
Diet	Are you currently dieting? Yes No	
	If yes, are you on a physician prescribed medical diet? Yes No	
	Number of meals you eat in an average day?	
	Rank salt intake: High Medium Low	
	Rank fat intake: High Medium Low	
Caffeine Intake	None Coffee Tea Cola	
	Number of cups/cans per day?	
Alcohol Use	Do you drink alcohol? Yes No	
	If yes, what kind?	How many drinks per week?
	Are you concerned about the amount you drink? Yes No	
	Have you considered stopping? Yes No	
	Have you ever experienced blackouts? Yes No	
	Are you prone to "binge" drinking? Yes No	
	Do you drive after drinking? Yes No	
Tobacco Use	Do you use tobacco? Yes No	
	Cigarettes - pks/day ________ Chew - #/day ________ Pipe - #/day ________ Electronic Cigarettes Cigars - #/day ________	
	Number of years ____________	Or year quit ____________
Drug Use	Do you currently use recreational or street drugs? Yes No	
	Have you ever given yourself street drugs with a needle? Yes No	
Sexual Activity	Are you sexually active? Yes No	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? Yes No	
Personal Safety	Do you live alone? Yes No	Do you have frequent falls? Yes No
	Do you have vision or hearing loss? Yes No	
	Do you have an Advance Directive or Living Will? Yes No	
	Would you like information on the preparation of these? Yes No	
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior, emotional, physical or sexual abuse. Would you like to discuss this concern with your provider? Yes No	

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WOMEN ONLY	
Date of last pap smear:	Date of last mammogram:
Date of last colonoscopy:	Date of last bone density scan (DEXA):
Number of pregnancies:	Number of live births:
Age of last menstruation:	
Have you had a D&C , hysterectomy, or Cesarean? Yes No	
Any urinary tract, bladder, or kidney infections within the last year? Yes No	
Any blood in your urine? Yes No	
Any problems with control of urination? Yes No	
Any problems with leakage of bowel movement? Yes No	
Do you usually get up to urinate during the night? Yes # of times ________ No	
Any hot flashes? Yes No	
Experienced any breast tenderness, lumps, or nipple discharge? Yes No	

MEN ONLY	
Date of last prostate and rectal exam:	
Date of last colonoscopy:	Date of last bone density scan (DEXA):
Do you usually get up to urinate during the night? Yes # of times ________ No	
Has the force of your urination decreased? Yes No	
Do you have any problems emptying your bladder completely? Yes No	
Any problems with control of urination? Yes No	
Any problems with leakage of bowel movement? Yes No	
Do you feel pain or burning with urination? Yes No	
Do you feel burning discharge from penis? Yes No	
Any blood in your urine? Yes No	
Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No	
Any difficulty with erection or ejaculation? Yes No	
Any testicle pain or swelling? Yes No	
Experienced any breast tenderness, lumps, or nipple discharge? Yes No	