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** _____

Charles E. Smith
LIFE COMMUNITIES

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 _____

Charles E. Smith
LIFE COMMUNITIES

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 _____

Charles E. Smith
LIFE COMMUNITIES

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) _____
☐ Hepatitis B _____
☐ Influenza _____
☐ Measles, Mumps, Rubella (MMR) _____
☐ Covid-19 _____
_____
_____

☐ Pneumonia (Prevnar-13) _____
☐ Pneumonia (Pneumovax-23) _____
☐ Shingles (Varicella) _____
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	

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	

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