BROOKSIDE HEALTH & WELLNESS

RACHEL FRIEND-LANTZ, CRNP

6500 Thayer Center
Oakland, MD 21550
301-334-5610

Patient:_____ _____ _____DOB_____
Last Name First Name Middle

Mailing Address:_____
Street City State Zip

Physical Address: (If mailing is a PO Box)_____

Email Address:_____ Would like access to our Patient Portal? Yes / No

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Gender (Circle one): M F Other Marital Status (Circle one): S M W D Soc.Sec#:_____

Ethnicity (Circle one): Hispanic or Latin/Not Hispanic or Latin Language (Circle one): English / Spanish / Other:_____

Race (Circle one): White / American Indian or Alaska Native / Asian / Native Hawaiian or Other Pacific / Black or African American / Hispanic / Other Race / Other Pacific Islander

Employer:_____Status (Circle one): Full time / Part time

Student? Yes / No ~ Status (Circle one): Full time / Part time ~ Primary Care Dr: _____

Responsible Party (Circle one): Self / Spouse / Parent / Other (Please specify)_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Do you have Insurance? Yes/No ~ Are you the primary card holder Yes / No ~ Dependent Card Holder Yes/No

Name of Insurance Company:_____
Please present your insurance card(s) and driver's license to the receptionist to copy for your chart

Spouse/Guardian Name:_____DOB_____Soc.Sec#:_____

Spouse/Guardian Employer:_____
Required if Spouse or Guardian is the primary subscriber on the Insurance Policy

Do you have an Advanced Directive? Yes / No Preferred Pharmacy:_____

I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to Brookside Health and Wellness. All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

_____ _____
Signature (Person signing must be age 18 or older or Legal Guardian/Custodian) Date

~~OVER~~

Patient Acknowledgement / Consent Form / Authorization

Use and Disclosure of Protected Health Information

Brookside Health and Wellness "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. These are available upon request. Please acknowledge receipt of the office's Notice of Privacy Practices by initialing below: _____ **(Patient's Initials)**

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare operations. We will discuss this request with you if there is a concern that the decision may not be in your best interest. We are bound by our agreement with you. _____ **(Patient's Initials)**

Brookside Health and Wellness has my permission to review my medical and prescription records, both internal and external, to assist them in my medical care. _____ **(Patient's Initials)**

Brookside Health and Wellness may leave messages on my answering machine regarding appointments, payments information or arrangements, test results and prescription information. By not signing, you do not agree with this policy and no information will be left on answering machine. _____ **(Patient's Initials)**

Brookside Health and Wellness considers patient confidentiality to be of utmost importance and concern. In an effort to ensure that your privacy is protected, please indicate below individuals that we are permitted to release your personal health information to:

_____

(Name) (Relationship) (Telephone number)

By signing this form, you consent to treatment of the person named on this form and our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already rendered treatment and/or made disclosures in trust on your prior consent.

As a courtesy to our patients, we will submit your claim to your insurance carrier at no extra charge. Patients are expected to make timely payment for services rendered. Patients not making payments or payment arrangements within 120 days of service may have their accounts sent to a collection agency, and be subject to the fees charged by the collection agency.

We do accept Visa, Mastercard and debit cards. We will take credit card payments over the phone if needed. Your credit card information will not be stored in any paper or electronic file, nor will we share it with anyone else.

Returned check policy: Any checks returned from the bank will assess a $30 fee.
No Show Policy: **Appointments must be cancelled within 24 hours of the scheduled appointment. There will be a $25 fee which must be paid before you can schedule another appointment.**

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

I attest that the information provided is true and correct as of the date below. I have read and understood the above conditions. I have also been given the opportunity to ask questions. By giving my signature I agree to the terms of this agreement.

_____ _____

Print & Sign (Person signing must be age 18 or older or Legal Guardian/Custodian) Date

Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Patient Intake Form

Reason for Visit: _____

- Current Medications (Please include over the counter medications, vitamins and supplements.)

Name/Strength	Provider	Name/Strength	Provider

- Medical History (Please review the list below and check any problems you have or have had in the past.)

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoparesis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Frequent Sinus Infections		Prostate Problems	
Allergies (Specify)		Gallstones		Psoriasis	
Anemia		Glaucoma		Reflux	
Anxiety Disorder		Gout		Rheumatoid Arthritis	
Asthma		Heart Attack		Rosacea	
Bipolar Disorder		Heart Condition (Specify)		Seasonal Allergies	
Blood Clot		Hepatitis (Specify A, B or C)		Seizures	
Blood Transfusion		High Blood Pressure		Sexually Transmitted Infections (Specify)	
Cancer (What Kind)		High Cholesterol			
Chronic Bronchitis		IBS		Stomach Ulcers	
Crohn's Disease		Kidney Disease		Stroke	
Colon Polyps		Kidney Infections		Tuberculosis	
Depression		Kidney Stones		Thyroid Disease	
Diabetes (Type 1 or 2)		Lupus		Ulcerative Colitis	
Diverticulitis		Melanoma or Skin Cancer		**Other medical problems not listed:**	
Drug Abuse		Migraines			
Eating Disorder		Osteoarthritis			

Name: _____ Date of Birth: _____
(First) (Middle) (Last)

- Medication Allergies (Please list below with reaction or check no known drug allergies)

_____ No Known Drug Allergies

Drug Name	Reaction	Drug Name	Reaction

- Family History (Please list which family members have had any of the following problems.)

Condition	Family Member	Condition	Family Member
Alcoholism		Migraines	
Asthma		Osteoporosis	
Breast Cancer		Ovarian Cancer	
Colon Cancer		Prostate Cancer	
Depression		Skin Cancer	
Diabetes		Stroke	
Heart Disease/Attack		Thyroid Disease	
High Blood Pressure		Uterine Cancer	
High Cholesterol		Other Cancer	
Lung Cancer		Other Mental Illness	

-Family History-		If Living		If Deceased	
		Age	*Health*	*Age at Death*	*Cause*
Father					
Mother					
Brothers/Sisters (Circle Sex)					
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				
Husband/ Wife (Circle Which)					
Sons/Daughters (Circle Sex)					
	M/F				
	M/F				
	M/F				
	M/F				
	M/F				

Name: _____ Date of Birth: _____
(First) (Middle) (Last)

- Social History (Circle One)

Do you have a concern for your safety? No Yes

Do you have a living will? No Yes

Marital Status: Single Engaged Married Separated Divorced Widowed

Highest Level of Education: <6th grade Jr. High High School College Graduate School

Occupation: _____

Do you exercise? No Yes – How often? _____ What type? _____

Are you exposed to smoke? Yes No

-Tobacco Use- (Please select below and circle your answer for corresponding questions)				
	Nonsmoker			
	Chews Tobacco/ Snuff User	How often? (Circle One) Daily Some Days		
	Former Smoker	How long has it been since you last smoked? (Circle One) <1 month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years >10 years		
		How often?	How many a day?	How soon after waking is your first?	Are you interested in quitting?
	Current Smoker	Daily Some Days	5 or less 6-10 11-20 21-30 31 or more	Within 5 minutes 6-30 minutes 31-60 minutes After 60 minutes	Rady to Quit Thinking about quitting Not ready to quit

Have you been sexually active in the last 12 months? No *Yes, (please circle all that apply below)*

- ***# of partners:*** 1 partner Multiple partners
- ***With?*** Men only Women only Both Men and Women
- ***Use Protection?*** No All the time Most of the time Half the time Sometimes
- ***Preventive strategies:*** Condoms The Pill Patch Ring IUD The Shot Vasectomy/Tubal None
- ***Have you ever had a sexually transmitted disease?*** No *Yes, (please list)* _____

_____

Drug Use: Have you used illegal drugs in the past? No Yes - In the past 12 months? No Yes

(please list) _____

Alcohol use: Do you drink alcohol? No *Yes, (please circle all that apply below)*

- ***How often?:*** Monthly or less 2-4 times monthly 2-3 times weekly 4 or more times a week
- ***How many daily?*** 1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more drinks
- ***Six or more drinks daily?*** Never Less than monthly Monthly Weekly Daily/Almost Daily

Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Caffeine Use: Do you drink caffeine daily? None 1-2 cups 2-3 cups 3-4 cups more than 4 cups

- Surgical History

Type of Surgery	Year	Type of Surgery	Year
Appendectomy		Knee or Hip Replacement	
Arthroscopy (Joint)		Mastectomy or Lumpectomy (Breast)	
Back or Neck		Polyp Removal (Colon)	
Cataract		Tonsillectomy/Adenoidectomy	
Cesarian Section		Thyroidectomy	
Cholecystectomy (Gallbladder Removed)		Tubal Ligation or Vasectomy	
Heart Surgery (Specify)		Plastic Surgery (Specify)	
Hernia		Other surgeries not listed:	
Hysterectomy			

- Hospitalizations: Have you been hospitalized in the past? No *Yes, please list reason and date*

_____

_____

- Preventative Maintenance

Vaccination Record *(If you do not know date, please list the year)*		
Vaccination	**Date of Vaccine**	**Other Vaccines and Date of Vaccine**
Flu Shot		
Tetanus Shot		
Pneumonia Shot		

Please list ALL other healthcare providers you currently see:

Provider/Practice Name	Specialty	Phone Number

- **Date of last colonoscopy:** _____

MEN ONLY – Do you perform self testicular exams regularly? No Yes

WOMEN ONLY					
Last Pap Smear		Last Menstrual Period		# of Pregnancies	
Have you had abnormal pap smears?	No Yes, Abnormal Pap date: _____	Age of first period		# of Live Births	
		# of Days in Cycle		# of Miscarriages	
Last Mammogram		# of Days in Flow		# of Abortions	
Have you had an abnormal mammogram?	No Yes, Abnormal Mam. date: _____	Are you menopausal?	No Yes	# of living children	
		Age at onset of menopause			
Do you perform self breast exams regularly?	No Yes				

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Authorization for Release of Information

I, _____ authorize, _____
(Patient Name, Parent or legal Guardian) (From)(Person or Organization disclosing information)

to release records to **Brookside Health and Wellness, LLC 6500 Thayer Center Oakland, MD 21550**

Photocopies of medical records regarding the following information: medical records or other information relative to my treatment or the treatment of my minor child: hospitalization, and/or outpatient care including psychosocial or psychiatric admission, drug/substance abuse, alcoholism, human immunodeficiency virus (HIV infection), acquired immunodeficiency syndrome (AIDS), or tests for HIV.

Authorization Expires _____ (Authorization expires 6 months after date of request unless noted otherwise)

Patient Full Name: _____ DOB: _____

Patient Address: _____ Social Security Number: _____

Phone/Fax: _____

Purpose of Release (Check Reason) :

- ☐ Request of Individual/Personal
- ☐ Transfer of care
- ☐ Insurance
- ☐ Other (Specify) _____

I authorize the use of telefax or photocopy of this form for the release and disclosure of the information described above. I understand that in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the persons listed above. I also understand that I may revoke this authorization at any time by written request (except for information already disclosed). I understand treatment is not dependent upon signing this authorization and that there is a potential for re-disclosure of my PHI (Protected Health Information) by the person or entity receiving the information. Authorization must be dated on or after the date of treatment. This authorization will expire in six (6) months after the date of request. If the patient is physically unable to sign authorization, a verbal authorization is accepted, a second witness is required.

_____ _____
(Patient, Parent or Legal Guardian) (Date)

_____ _____
(Witness) (Date)

_____ _____
(Witness) (Date)