



Dr. John G. Roth & Associates, P.A.

3459 St. John's Lane, Suite 3

Ellicott City, MD 21042

**NEW PATIENT
INFORMATION FORM**

Demographic Information:

First Name: _____

Middle Initial: ____

Last Name: _____

Date of Birth: ____/____/____

SSN: ____-____-____

Male Female

Address: _____

City: _____

State: _____ Zip: _____

E-Mail: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

We may contact you via:

Home Phone Cell Phone Work Phone

We may leave messages with:

Patient only Spouse Anyone answering

Employer: _____

Occupation: _____

Race: _____

Preferred Language: _____

Marital Status:

Single Married Partnered Separated

Divorced Widowed

Primary Doctor Information

Name: _____

Doctor's Phone: _____

Date of Last Visit: _____

Preferred Pharmacy Information

Name: _____

Location: _____

Pharmacy's Phone: _____

Emergency Contact Information

Name: _____

Relationship to patient: _____

Phone Number: _____

How did you hear about the office?



Insurance Information:

Primary Insurance: _____

Co-Pay Amount (Specialist): _____
Co-Pay is due prior to visit.

Policy ID#: _____

Group ID#: _____

Policy Holder Information

Name: _____
Self / Spouse / Parent / Other

Employer: _____

Date of Birth: ____/____/_____

Secondary Insurance: _____

Policy ID#: _____

Group ID#: _____

Policy Holder Information

Name: _____
Self / Spouse / Parent / Other

Employer: _____

Date of Birth: ____/____/_____

Responsible Party, if the patient is a minor:

Name: _____

Relationship to patient: _____

Phone Number: _____

Address: _____

Authorization:

I, with my signature below, authorize Dr. John Roth to furnish information to the identified insurance carriers for prior authorization, pre-certification or payment of health care services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed, and I assign all payments for these services to Dr. John Roth I understand that I am responsible for copayments, deductibles, all non-covered services, proper referrals and use of participating lab and radiology services. I further understand that my contract with my insurance carrier may or may not cover some services and that is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I am responsible for all charges that are incurred and I am responsible for all charges whether covered or not by insurance.

Patient / Guardian Signature & Date:

Please present Photo ID and Insurance Card.



MEDICAL HISTORY FORM

Height: _____ Weight: _____ Shoe Size: _____

Your Allergies:

- I have no allergies
- I have the following allergies:

Your Medications:

- I take no medications
- I take the following medications (or attach list):

Your Medical History: Have you ever had any of the following? Please check.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dialysis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> DVT/Blood Clot | <input type="checkbox"/> HIV – AIDS | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Gout | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stomach Problem |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |

Other Medical Conditions: _____

Your Surgeries: (include all major and minor procedures – denote with * if you had any complications)

Your Family History: (have your parents, grandparents or siblings had any of the following conditions?)

Arthritis Cancer Diabetes Gout Heart Disease Hypertension Poor Circulation Sickle Cell Stroke T.B.

Other: _____

Your Social History:

Use of Alcohol: Never Rare Occasional Moderate Daily

Use of Caffeine (coffee, tea, soda): Never Rare Occasional Moderate Daily

Exercise: Never Rare Occasional Weekly Several Times a Week Daily

Use of Street Drugs: Never Occasional Moderate Daily

Street Drugs Used: _____

Use of Tobacco: Never Quit – How Long Ago? _____ Smoke _____ Packs / Day _____ Years

PODIATRIC HISTORY FORM

What is the chief complaint for which you wish to be evaluated and treated?

How long have you had this problem?

Have you seen another doctor for this condition?

What treatments have you attempted for this condition?

Is there anything else we should know about this problem?

Do you experience any of the following problems to your feet or legs? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Swelling / Edema | <input type="checkbox"/> Fever / Chills |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Redness | <input type="checkbox"/> Nail Changes |
| <input type="checkbox"/> Cramping (while walking) | <input type="checkbox"/> Cramping (while at rest) | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Recent Weight Change | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Drainage / Weeping |
| <input type="checkbox"/> Night Pain (wakes you up) | <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Itching | <input type="checkbox"/> Joint Aches |
| <input type="checkbox"/> Stabbing Calf Pain | <input type="checkbox"/> Wounds / Ulcers | <input type="checkbox"/> Blood Clots |

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

Patient and/or Legal Guardian Signature

Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- ☞ To family members or close friends who are involved in your health care
- ☞ For certain limited research purposes
- ☞ For purposes of public health and safety
- ☞ To government agencies for purposes of their audits, investigations and other oversight activities
- ☞ To government authorities to prevent child abuse or domestic violence
- ☞ To the FDA to report product defects or incidents
- ☞ To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- ☞ When required by orders, search warrants subpoenas, and as otherwise required by law.

Patient Rights

As our patient, you have the following rights:

- ☞ To have access to and/or a copy of your health information
- ☞ To receive an accounting of certain disclosures we have made of your health information
- ☞ To request restrictions as to how your health information is disclosed
- ☞ To request that we communicate with you in confidence
- ☞ To request that we amend your health information
- ☞ To receive notice of our privacy practices

If you have a question, concern, or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person(s) whom you may contact.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices (or have been given the opportunity to read if I chose to do so). I understood the notice.*

Patient Name (Print)

Signature

Relationship to Patient

Date

*You may refuse to sign this acknowledgement.