Dr. John G. Roth & Associates, P.A.
2 East Rolling Crossroads, Suite 55
Catonsville, MD 21228

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.

☐ Acid Reflux	☐ Diabetes	☐ Hepatitis	☐ Neuropathy
☐ Arthritis	☐ Dialysis	☐ High Cholesterol	☐ Poor Circulation
☐ Asthma	☐ DVT/Blood Clot	☐ HIV – AIDS	☐ Sickle Cell
☐ Bleeding	☐ Gout	☐ Hypertension	☐ Stomach Problem
☐ Blood Thinner	☐ Heart Attack	☐ Kidney Disease	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Liver Disease	☐ 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 Stoke 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)

☐ Numbness	☐ Excessive Bleeding	☐ Nausea / Vomiting
☐ Tingling	☐ Swelling / Edema	☐ Fever / Chills
☐ Burning	☐ Redness	☐ Nail Changes
☐ Cramping (while walking)	☐ Cramping (while at rest)	☐ Dry Skin
☐ Recent Weight Change	☐ Varicose Veins	☐ Drainage / Weeping
☐ Night Pain (wakes you up)	☐ Skin Discoloration	☐ Stiffness
☐ Cold Feet	☐ Itching	☐ Joint Aches
☐ Stabbing Calf Pain	☐ Wounds / Ulcers	☐ 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.

_____ Date: _____

Patient and/or Legal Guardian Signature

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 ACKNOWLEGDEMENT 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.