



## New Patient Registration Form

Full Name

Date of Birth

Street Address

City

State

Zip Code

E-mail Address:

Phone Number (Preferred)

Phone Number (Secondary)

Occupation

Employer

Emergency Contact

Relationship

Phone Number

*If patient is under the age of 18, please provide information for the parent or legal guardian below.*

Parent/Legal Guardian

Phone Number

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### INSURANCE INFORMATION

Insurance Company

ID Number

Phone Number

Group Number

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## PREFERRED PHARMACY

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Pharmacy Name

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Phone Number

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Address

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Fax Number

---

City

---

State

---

Zip Code

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## CURRENT MEDICATION LIST

(If none, leave blank. If more than eight, please provide a separate list of all medications.)

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Medication 1 Name

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Directions

---

Medication 2 Name

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Directions

---

Medication 3 Name

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Directions

---

Medication 4 Name

---

Directions

---

Medication 5 Name

---

Directions

---

Medication 6 Name

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Directions

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Medication 7 Name

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Directions

---

Medication 8 Name

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Directions

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## ALLERGIES

**Allergies** (List all allergies, type of reaction, and date of last reaction)

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## MEDICAL HISTORY

**Childhood Illnesses?** (Please include dates)

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**Accidents?** (Please include dates)

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**Chronic Illnesses?** (Please include date of onset)

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**Surgeries?** (Please include dates)

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**Have you ever experienced problems with anesthesia?**

If yes, please explain below.

YES

NO

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## IMMUNIZATION RECORD

(Please estimate the date of your last vaccine. If unknown, OK to leave blank.)

Influenza	<input type="text"/>	Hep. A	<input type="text"/>	Prevnar-13	<input type="text"/>
COVID-19	<input type="text"/>	Hep. B	<input type="text"/>	Prevnar-20	<input type="text"/>
TDAP	<input type="text"/>	Zoster	<input type="text"/>	Prevnar-23	<input type="text"/>
Shingles	<input type="text"/>	Typhoid	<input type="text"/>	Pneumonia	<input type="text"/>
Meningitis	<input type="text"/>	HPV	<input type="text"/>		

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## HEALTH MAINTENANCE

(Please estimate the date of your last test/exam. If unknown, OK to leave blank.)

Bone Density Scan	<input type="text"/>	Hearing Test	<input type="text"/>	Mammogram	<input type="text"/>
Tuberculosis Test	<input type="text"/>	Eye Exam	<input type="text"/>	Pelvic Exam	<input type="text"/>
Cardiac Stress Test	<input type="text"/>	Dental Exam	<input type="text"/>	Pap Smear	<input type="text"/>
Colonoscopy	<input type="text"/>	Physical Exam	<input type="text"/>	Prostate Exam	<input type="text"/>
EKG	<input type="text"/>	Breast Exam	<input type="text"/>	PSA Labs	<input type="text"/>

**Other relevant health maintenance?** Please include dates.

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## FAMILY HISTORY

(Please describe any relevant illnesses and age of onset.)

Mother	<input type="text"/>
Father	<input type="text"/>
Siblings	<input type="text"/>
Maternal Grandmother	<input type="text"/>
Maternal Grandfather	<input type="text"/>
Paternal Grandmother	<input type="text"/>
Paternal Grandfather	<input type="text"/>

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## SOCIAL HISTORY

(Please describe any relevant illnesses and age of onset.)

### SMOKING STATUS

- Current Smoker
- Occasional Smoker
- Never

If you are a former smoker, when did you quit?

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If you are a current smoker, at what age did you start smoking?

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Method of use? (ex. Cigarettes, cigars, vaping, etc.)

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Number of packs per day? \_\_\_\_\_

Date of last Low Dose Chest CT? \_\_\_\_\_

### CAFFEINE INTAKE

- None
- Moderate
- Excessive

How much caffeine do you consume in a normal day?

(Example: 2 cups of coffee a day.)

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Describe your diet:

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### RECREATIONAL DRUG USE

- Regularly
- Occasionally
- Never

If you regularly or occasionally use recreational drugs, please identify the drug, method of use, and frequency of use.

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### EXERCISE HABITS

- Regularly
- Occasionally
- Never

Describe your exercise.

(Example: "Jogging one mile twice/week.")

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### ALCOHOL USE

- Regularly
- Occasionally
- Never

Number of drinks per day/week/month?

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### ADVANCE DIRECTIVE

Do you have a written will or advance directive?

- Yes
- NO

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## WOMEN'S HEALTH

(if applicable)

Date of last period? \_\_\_\_\_

History of STD's?

Are your periods regular?

Yes

No

Age at onset of period? \_\_\_\_\_

Age at cessation of period? \_\_\_\_\_

Have you ever had an abnormal pap smear?  
(Describe abnormality and time frame)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Pregnancy History

Total number of pregnancies?	
Number of full-term births?	
Number of premature births?	
Number of abortions?	
Number of miscarriages?	
Number of ectopic pregnancies?	
Number of multiple birth pregnancies?	
Number of living children?	

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## OTHER PROVIDERS

(Please name any specialists that you currently see and their specialty)

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Specialty



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## HIPAA Acknowledgment

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

It is the policy of Annapolis Family Medicine not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may responsibly infer from the circumstance (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate that below, so that we may best serve you.

By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient/Representative Signature\*

\_\_\_\_\_  
Date

\*Signing will hereby acknowledge receipt of the AFM HIPAA Policy.

\*\*Any updates to this form must be made in person.



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## Payment Policy

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we participate with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
2. **Copayments and deductibles.** All copayments and deductibles must be paid at the time of service. This requirement is part of your contract with your insurance company.
3. **Non-covered services.** Please be aware that some services you receive may be non-covered or not considered reasonable.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Non-payment.** Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
7. **Missed appointments.** Our policy is to charge \$75.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have reviewed and agreed to the above AFM Patient Payment Policy.

\_\_\_\_\_  
Patient/Representative Signature\*

\_\_\_\_\_  
Date

\*Signing will hereby acknowledge receipt of the AFM Payment Policy.



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## Medical Records Request Form

Name : \_\_\_\_\_ DOB : \_\_\_\_\_

Home Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_

Phone Number : \_\_\_\_\_

**I hereby authorize Annapolis Family Medicine, LLC to obtain/release my medical records to/from:**

Provider or Practice Name : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_

Phone Number : \_\_\_\_\_ Fax Number : \_\_\_\_\_

1. I understand that this authorization will expire 365 days from the date I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying Annapolis Family Medicine in writing. Revocation will be effective on the date notified, except to the extent action has already been taken in reliance upon this authorization.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that this authorization may be used to obtain any medical information pertaining to substance abuse, mental health, or HIV related testing

### **Records Requested**

- |  |   |
|--|---|
| <input type="checkbox"/> Last Office Visit | <input type="checkbox"/> Last Lab Results           |
| <input type="checkbox"/> Immunizations     | <input type="checkbox"/> EKG/Cardiac Testing        |
| <input type="checkbox"/> Radiology         | <input type="checkbox"/> All of the above (3 years) |

### **Purpose of Disclosure**

- |  |
|--|
| <input type="checkbox"/> Changing Physicians |
| <input type="checkbox"/> Personal Use        |
| <input type="checkbox"/> Continuing Care     |

Patient Signature : \_\_\_\_\_

Printed Name : \_\_\_\_\_

Date : \_\_\_\_\_



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## Health & Wellness Program

Annapolis Family Medicine is proud to present our Health & Wellness Program. This program offers amenities and health benefits beyond those covered by private health insurance plans and will allow us the needed resources to enhance your health care by offering a more integrative model.

The Health & Wellness Program offers the following enhanced services:

- **Health Nurse and assistance by direct telephone line and electronic services.** With a direct phone number and email, you will have access to our Health & Wellness Program Nurse. Our Health & Wellness Nurse will help coordinate care with our providers to ensure medical needs are met in the safest, most efficient means possible. The following services can often be handled without an office visit saving the patient both time and money:
  - Same day triage, visit and treatment of an acute illness.
  - Telephone triage and treatment of minor medical problems without an office visit. By using standard protocols reviewed by the providers, some medical issues such as uncomplicated rashes, respiratory, gastrointestinal, and urinary tract infections can be handled without an office visit, saving the patient time, money and limiting exposure of certain illnesses.
  - Telephone analysis and triage for ordering special tests such as X-rays or other specialized tests prior to your office visit.
  - Assistance with “special” limited medications (such as but not limited to motion sickness patches and travel medications) and other requests after a careful review of the health record.
  - Routine medication refills. For those participating members, this request can be reviewed and processed by our Health & Wellness Nurse.
- **Enhanced Wellness Exam.** Currently insurance companies only cover 1 basic preventative exam a year. With the Health & Wellness program, in addition to the annual recommended preventive exam, you will receive a more extensive cardiac analysis and risk assessment as well as an enhanced nutritional and psychological assessment.
- **Annual Nutrition Screening.** An in person individualized assessment of a treatment plan will be provided by our nutritionist Tina Hinchman MS, MBA, CPT, CHC.
- **Annual Psychological Assessment.** In collaboration with our in-house mental health specialist, Health & Wellness patients will have access to an annual psychological assessment/consult personalized to the patient.
- **Self-Pay Patients.** The Wellness Program will offer special savings and affordable access for those patients who are without health insurance or for those with a high-deductible plan.
- **Consultations / Evaluations** for the following integrative supplemental therapies will be available under your Health & Wellness program: Hormone Replacement Therapy, CBD Oil, Medical Weight Loss, Medical Botox, Medicinal Cannabis

### Additional Benefits

- Consultations for travel medicine.
- Virtual Visits (per provider discretion)

**Membership Fee:** We offer membership plans for an individual or a family. A family membership would cover two spouses, plus any dependents under 26 years old. Membership fees can be paid monthly, quarterly, or annually.

Individual Membership:	\$125.00 monthly	\$375.00 quarterly	\$1500.00 annually
Family Membership:	\$250.00 monthly	\$750.00 quarterly	\$3000.00 annually

The benefits of the AFM’s Health & Wellness Program are numerous. This program will help eliminate the need for frequent office visits, thus saving you time, money and limiting the exposure of contagious illnesses. For those who choose these services, this program will provide beneficial enhancements to your medical care and overall wellness, allowing for an integrative approach utilizing our diverse team here at AFM. We look forward to working with you to provide the highest quality of medical care.



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## **Health & Wellness Program**

### Frequently Asked Questions

#### **How can this save me money? Will I still have to pay a co-payment each time I come in?**

For those of you with high deductibles or high copayments, we will do our best to work with you to limit your time spent in the office. If we can keep you out of the office by refilling your medications or giving straightforward medical advice remotely, we will do that. Thus, allowing you to save on the cost of an office visit and copay.

#### **What extra services am I getting for this money?**

If needed, you are getting extra time with providers, same day visits, LESS office visits for routine medication refills (if appropriate), consultations with our psychologist and dietician, consultations for hormone replacement therapy, medicinal cannabis, CBD Oil, DOT & Coast Guard physicals. Federal urine drug screening, and cosmetic Botox, and a direct line to our Health & Wellness nurse to get your questions and requests answered promptly.

#### **Can I pay for the fee with my HSA/FSA account? Will it be covered?**

Certainly! All insurance plans differ, so while we can't promise it will be covered, we'd be happy to provide a receipt to submit.

#### **What changes with my insurance with the wellness program?**

Nothing! Your insurance will be used IDENTICALLY to how it is currently used. The additional cost is simply put towards the extra services we are offering. The fee covers the services that are not traditionally covered by insurance.

#### **Will my insurance cover the annual fee?**

No. However, certain Health Savings Account (HSA) and Flexible Spending Account (FSA) plans may reimburse for all or part of the fee. Each plan is different, so it is always safe to check with your human resources representative or plan manager to find out.

#### **Will you still bill my insurance?**

Yes, there will be no change in how we currently bill your insurance. We will continue to bill for office visits and procedures, and charge copays, co-insurances, and deductibles as we currently do. Our annual fee covers the services that your insurance and/or Medicare does not cover.

#### **What if I don't have insurance?**

For our self-pay patients who pay at the time of the visit, we offer discounted prices for visits and in-office procedures. In addition, our ability to triage patients via phone will allow us the ability to limit unnecessary visits.

#### **Can I un-enroll from the program at any time?**

Yes, you can stop your membership and get a prorated refund for the membership fee at any time by giving 30 days notice. If you wish to stop the membership, simply write a letter requesting discontinuation of services.

#### **What prompted this change?**

Lower reimbursement rates and increased requirements by insurance companies are leaving providers with little time for meaningful interaction. This program will allow us the needed resources to enhance your health care. Our goal is to have more time and resources to focus on patient care, specifically on prevention and minimizing the need for treatment.



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## **Health & Wellness Program**

### Specialized Services Consultation Agreement

Annapolis Family Medicine ("AFM") provides the highest quality care for treating *the whole patient*. To that end, our practice strives to incorporate all beneficial methods to treat you and get you to your optimal level of health and wellness. Most health insurance plans do not cover services that we believe to be beneficial for many people to achieve an optimal level of wellness. This Specialized Consultation Agreement ("Agreement") will enable AFM to devote more resources to helping you achieve your personal optimum health and wellness.

This Agreement will not change AFM's practice of submitting bills to your health insurance provider for all covered services. Instead, this Agreement is strictly for non-covered services based on the following terms:

1. **Term:** This Agreement will be effective on the date the Agreement is signed by both parties ("Effective Date") and continue for one year. Each year, we will have the opportunity to renew this agreement on mutually agreeable terms.
2. **Consultation:** Your AFM provider will schedule a one-on-one meeting with you. At this consultation, your AFM provider will determine whether your health may benefit from certain specialized services that are not covered by your health insurance provider. This consultation will be separate from any office visit that might be covered by your health insurance provider and will focus solely on the incorporation of the specialized services into your healthcare routine.
3. **Specialized Services:** During our consultation, we will discuss integrative supplemental therapies for your specific health conditions.
4. **Consultation Fee:** Fee can be paid monthly, quarterly, or annually.
  - a. Individual Patient: \$125.00 (monthly) OR \$375.00 (quarterly) OR \$1500.00 (annually)
  - b. Family: \$250.00 (monthly) OR \$750.00 (quarterly) OR \$3000.00 (annually)
5. **Follow-up Service:** At the conclusion of your consultation (either immediately in the office or promptly thereafter), your AFM provider will recommend which, if any, Specialized Services could contribute to your health and wellness. If you decide to incorporate one or more recommended Specialized Services into your treatment, you may incur additional charges. AFM will first discuss these charges and obtain your written consent prior to providing any Specialized Services.
6. **Entire Agreement:** This Agreement constitutes the entire agreement and sets forth the entire understanding between the parties with respect to this consultation agreement.
7. **Cancellation of Membership :** Membership can be cancelled and you will receive a prorated refund within 30 days by writing us a letter requesting discontinuation of services and membership.

After reading the terms of the Specialized Services Consultation Agreement, the parties have agreed to execute this agreement as of the Effective Date.

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### **Payment Information**

Name on Card : \_\_\_\_\_

Billing Address : \_\_\_\_\_  
Street Address City State ZipCode

Credit Card # : \_\_\_\_\_ Expiration Date : \_\_\_\_\_ CVV : \_\_\_\_\_

Signature : \_\_\_\_\_ Date : \_\_\_\_\_