Angela Jones MD LLC
Telephone: 410-881-0097
600 Ridgely Avenue, Suite 110
Annapolis, MD 21401
12158 Central Ave
Mitchellville, MD 20721
9135 Piscataway Rd, Ste 420
Clinton, MD 20735

NEW PATIENT QUESTIONNAIRE

Name (Last, First)	**Birthdate**	**Age**	**Sex** M F
Appointment Date	**Physician:** Dr Angela Jones		

Did another physician refer you? ☐ Yes ☐ No ☐ Self-Referral

Referring MD Name ______________________
Street Address ______________________
City, State, Zip Code ______________________
Phone (   ) __________ **Fax (   )** __________

If you have a primary physician, other than the referring physician, please complete so we can send them a report of your office visit

Primary Care MD Name ______________________
Street Address ______________________
City, State, Zip Code ______________________
Phone (   ) __________ **Fax (   )** __________

Would you like this visit information sent to any physician other than those listed above? ☐ Yes ☐ No

MD Name ______________________
Street Address ______________________
City, State, Zip Code ______________________
Phone (   ) __________ **Fax (   )** __________

What is the reason for your appointment today?

____
____
____
____
____
____

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Patient Contact Information Form

PATIENT'S FULL NAME:____

ADDRESS:____

*CITY*________________________*STATE* ________________*ZIP*______________________

PATIENT'S SS#:______________________ **PATIENT'S DOB:**________________________

WORK PHONE:____________________ **CELL PHONE:** ___________________________
HOME PHONE: ______________________

PRIMARY INSURANCE COMPANY: ____

POLICY NUMBER: _______________________ **GROUP NUMBER:** __________________

NAME OF INSURED____
RELATIONSHIP TO PATIENT AND DATE OF BIRTH: ___________________________

SECONDARY INSURANCE COMPANY: ____

POLICY NUMBER: _______________________ **GROUP NUMBER:** __________________

NAME OF INSURED____
RELATIONSHIP TO PATIENT AND DATE OF BIRTH: ___________________________

EMPLOYER : ____

PATIENT PHARMACY CONTACT INFO: ______________________________________
____
____

EMERGENCY CONTACT NAME: ____
EMERGENCY CONTACT RELATIONSHIP:____________________________________
EMERGENCY CONTACT PHONE NUMBER:____________________________________

SPOUSE NAME:____
SPOUSE CONTACT INFORMATION:_______________________________________
____
____

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Financial Policy

Billing through Insurance

I GIVE **ANGELA JONES MD LLC** AND ITS AGENT THE RIGHT TO FILE INSURANCE CLAIMS IN MY BEHALF FOR OFFICE VISITS, HOSPITALIZATIONS OR ANY OTHER SERVICES PROVIDED BY THE PHYSICIANS OR THE STAFF OF **ANGELA JONES MD LLC**.

I UNDERSTAND THAT, IT IS MY DUTY TO PROVIDE **ANGELA JONES MD LLC** AND ITS AGENTS WITH THE CORRECT AND UPDATED INSURANCE CARD AND ALL THE NECESSARY INFORMATION TO FILE SUCH CLAIMS.

I UNDERSTAND THAT, IF MY INSURANCE COMPANY DOES NOT PAY FOR SUCH CLAIMS WITHIN 45 DAYS, I AM RESPONSIBLE AND WILL PAY THE BALANCE WITHIN 45 DAYS AFTER THE DATE OF SUCH VISIT.

I UNDERSTAND THAT IF I AM INSURED BY A PLAN THAT **ANGELA JONES MD LLC** DOES NOT HAVE A PRIOR ARRANGEMENT WITH, A CLAIM WILL BE SENT TO MY INSURANCE COMPANY ON AN UNASSIGNED BASIS. THIS MEANS THE INSURER WILL SEND THE PAYMENT DUE DIRECTLY TO ME. THEREFORE, **ANGELA JONES MD LLC** CHARGES FOR MY CARE ARE DUE AT THE TIME OF SERVICE.

Usual and Customary Rates

WE ARE COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT WE BELIEVE TO BE REASONABLE AND CUSTOMARY FEES FOR OUR REGION AND SPECIALTY.

Co-Pay Charges

I UNDERSTAND THAT **ANGELA JONES MD LLC** HAS MADE PRIOR ARRANGEMENTS WITH MANY INSURANCE COMPANIES AND OTHER HEALTH PLANS TO ACCEPT AN ASSIGNMENT OF BENEFITS. MY INSURANCE COMPANY WILL BE BILLED FOR SERVICES RELATED TO OFFICE VISITS AND/OR HOSPITAL STAYS, AND I WILL BE REQUIRED TO PAY A COPAYMENT AT THE TIME OF THE OFFICE VISIT.

Past-Due Balances

OVERDUE BALANCES ON PATIENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY. LEGAL FEES WE MAY INCUR TO SECURE PAST DUE BALANCES WILL BE ADDED TO YOUR ACCOUNT.

Returned Checks or Cancelled Credit Card Payments

FOR CHECKS RETURNED TO US AS UNPAID BY YOUR BANK AND FOR CREDIT CARD TRANSACTIONS DECLINED OR CANCELLED BY YOUR CARD COMPANY, WE WILL CHARGE A $50.00 FEE.

No-Show Fee

I AM REQUIRED TO CONTACT THE OFFICE IF I AM UNABLE TO KEEP MY APPOINTMENT. IF THE OFFICE DOES NOT RECEIVE NOTIFICATION FROM ME TO CANCEL OR RESCHEDULE APPOINTMENTS THERE WILL BE A $25 FEE.

Patient Signature______________________________________ Date____________________

Printed Name______________________________________ Date of Birth_______________

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PRIVACY POLICY

I understand that the patient's health information is private and confidential. I understand that ***Angela Jones MD LLC,*** work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that ***Angela Jones MD LLC,*** may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations [In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.].

Angela Jones MD LLC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Angela Jones MD LLC may update this Acknowledgment and "Notice of Privacy Practices". If I ask, ***Angela Jones MD LLC*** will provide me with the most current "Notice of Privacy Practices."

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Angela Jones MD LLC has established procedures, which help them, meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist ***Angela Jones MD LLC*** by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Patient Signature____ Date____________________

Printed Name____ Date of Birth________________

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PATIENT RECORD OF DISCLOSURE

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home telephone # _________________
___ leave message with detailed information
___ leave message with call-back number only

*Work telephone #*_________________
___ leave message with detailed information
___ leave message with call-back number only

Written communication
___ can mail to my home address
___ can mail to my work/office address

___can fax to work fax# ____________

Email address for the patient portal____

Patient signature:______________________________ Date: _______________

Print name:__________________________________ DOB: _______________

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Past Medical History

Please indicate if you have ever been **diagnosed** with any of the following conditions.
If Yes, please give an explanation.

SYSTEM	YES	NO	PATIENT COMMENTS
CARDIOVASCULAR			
Irregular Heartbeat	☐	☐	
Blood Clotting Disorder	☐	☐	
Heart Failure	☐	☐	
High Cholesterol	☐	☐	
Heart Attack/Angina	☐	☐	
High Blood Pressure	☐	☐	
Prosthetic/Artificial Heart Valve	☐	☐	
Blockage of Blood Vessels	☐	☐	
GASTROINTESTINAL/ GENITOURINARY/ RESPIRATORY			
Stomach Ulcers	☐	☐	
Liver Disease/Hepatitis	☐	☐	
Kidney/Bladder Disease	☐	☐	
Lung Disease	☐	☐	
Tuberculosis	☐	☐	
OTHER			
Alcohol/ Drug Abuse	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Immune System Disorder	☐	☐	
Thyroid Disease	☐	☐	
Sexually Transmitted Disease	☐	☐	

OTHER PAST MEDICAL HISTORY (Please list all medical conditions not mentioned above)____

____

____

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PREVIOUS OPERATIONS/HOSPITALIZATIONS:

Date	Hospital	Problem/Operation

CURRENT MEDICATIONS (Please list all medications, i.e. over-counter medications and herbal meds)

Medication/ Dosage	Medication/ Dosage

Allergy History

Have you ever had an allergic reaction to any medication? ☐ Yes ☐ No If yes, please list medication and reaction.

____

Social History

Birthplace: ______________ Highest Grade completed in School: ______________

Current Occupation: ______________

Relationship/Marital status: ______________

Have you ever smoked cigarettes: ☐Yes ☐No

If yes, how much do you currently smoke per day? ☐ ½ pack ☐1 pack ☐2 packs ☐> 2 packs

If you previously smoked, how long ago did you quit? ☐ 1 year ☐1-5 years ☐> 5 years

How many years did you smoke? ______________

Have you had significant exposure to: Pesticides? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No Type______________ How often/much? ______________

Do you exercise? ☐Yes ☐No If yes, how much? ☐Rarely ☐Occasionally ☐>3 times/week

Dietary Restrictions? ______________

Family History:

Family Member	*Age (or age at death)*	*Medical Problems*
Father		
Mother		
Siblings		

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Children ________________ ______________________________

Review of Systems

Have you experienced any of the following symptoms? Please circle Yes, No, or Unknown. If yes, please give an explanation.

SYSTEM	Patient: Circle Response			Physician / Patient Comments
GENITOURINARY				❑ WNL
Blood in urine	YES	NO	UNKNOWN	
Burning with urination	YES	NO	UNKNOWN	
Difficult/frequent urination	YES	NO	UNKNOWN	
Lack of bladder control	YES	NO	UNKNOWN	
Sexually transmitted disease	YES	NO	UNKNOWN	
Change in sexual function	YES	NO	UNKNOWN	
HEMATOLOGY/LYMPHATIC				❑ WNL
Easy bruising	YES	NO	UNKNOWN	
Frequent bleeding	YES	NO	UNKNOWN	
Enlarged lymph nodes	YES	NO	UNKNOWN	
INTEGUMENTARY SKIN & BREASTS				❑ WNL
Unusual or prolonged rashes	YES	NO	UNKNOWN	
Breast pain or lump	YES	NO	UNKNOWN	
Change in hair or nails	YES	NO	UNKNOWN	
MUSCULOSKELETAL				❑ WNL
Joint/muscle stiffness or pain	YES	NO	UNKNOWN	
Weakness of muscles or joints	YES	NO	UNKNOWN	
Back pain	YES	NO	UNKNOWN	
Difficulty walking	YES	NO	UNKNOWN	
NEUROLOGICAL				❑ WNL
Headaches	YES	NO	UNKNOWN	
Numbness/tingling sensation	YES	NO	UNKNOWN	
Weakness or paralysis	YES	NO	UNKNOWN	
Convulsions or seizures	YES	NO	UNKNOWN	
Change in memory/concentration	YES	NO	UNKNOWN	
Loss or blurring of vision	YES	NO	UNKNOWN	
or double vision	YES	NO	UNKNOWN	
Black-outs/dizziness	YES	NO	UNKNOWN	
Memory loss or confusion	YES	NO	UNKNOWN	
Other neurological problems	YES	NO	UNKNOWN	
PSYCHIATRIC				❑ WNL
Nervousness	YES	NO	UNKNOWN	
Depression	YES	NO	UNKNOWN	
Other	YES	NO	UNKNOWN	
RESPIRATORY				❑ WNL
Breathing problems/shortness of breath	YES	NO	UNKNOWN	
Coughing up blood	YES	NO	UNKNOWN	
Chronic cough	YES	NO	UNKNOWN	

***I have truthfully to the best of my knowledge, included all of the information requested above.**

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Patient Signature **Date**