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

NEW PATIENT QUESTIONNAIRE

Name (Last, First, Middle Initial)	Age	**Birthdate**	**Sex** M F

Race	**Marital Status**	**Occupation**	**Email address**

How were you referred to us? Please place a X next to your selection

☐ **Google** ☐ **Web MD** ☐ **Health Grades** ☐ **Internet** ☐ **Physician**
☐ **Family/ Friend** ☐ **Medstar Health** ☐ **Patient** ☐ **Vitals.com**

Please tell us your Primary Care Physician Name

Primary Care Physician First and Last Name _____
Street Address _____
City, State, Zip Code _____
Phone ( ) _____ Fax ( ) _____

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

Physician Name _____
Street Address _____
City, State, Zip Code _____
Phone ( ) _____ Fax ( ) _____

Describe 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**:_____

HOME PHONE:_____ **CELL PHONE:** _____
WORK 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 : _____

PHARMACY NAME : _____
PHARMACY ADDRESS: _____
PHARMACY TELEPHONE# _____

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 or Guardian Signature_____ Date_____

Printed Name_____Date_____

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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**_____

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

Written communication

_____ can mail to my home address

_____can mail to my work/office address

Email Address_____

Patient or Guardian 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. **Please place an X next to your answer.**

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 and Dosage	Medication and Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergy History

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

_____

Social History

Birthplace: _____ Highest Grade completed in School: _____

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? _____

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	***Current Age (or age at death)***	***List Any Medical Problems***
Father	_____	_____
Mother	_____	_____
How many Siblings	_____	_____
	_____	_____
How many Children	_____	_____

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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.**

_____ _____

Patient or Guardian Signature **Date**