Dr. Helmut Pfalz
110 Hospital Rd, Suite 214
Prince Frederick, MD 20678

NAME: _____ DOB: _____ VISIT DATE: _____

REASON FOR CONSULT _____ WORK/ACCIDENT RELATED? □ YES □ NO

REFERRING PHYSICIAN: _____

DRUG/ LATEX/ TAPES ALLERGIES: YES____NO__

WHAT HAPPENS IN AN ALLERGIC REACTION? _____

LIST MEDICATIONS & DOSAGES _____

_____

DO YOU SMOKE? □YES □ NO HOW MUCH PER DAY _____

DO YOU DRINK ALCOHOL? □YES □ NO IF, WHAT & HOW MUCH _____

ARE YOU PREGNANT? □YES □ NO IF YES, DATE OF EXPECTACY _____

DO YOU USE A SEATBELT? YES____NO__ (CHILDREN) CAR SEAT: YES____NO__

DO YOU LIVE WITH: SPOUSE_____ CHILDREN____ PETS_____OTHER_____

PERSONAL MEDICAL HISTORY

ANEMIA: NO YES	EMPHYSEMA: NO YES	HIGH CHOLESTEROL: NO YES
ATRIAL FIBRILLATION: NO YES	ENLARGED PROSTATE: NO YES	IRRITABLE BOWEL : NO YES
AUTOIMMUNE DISEASE: NO YES	FIBROMYALGIA: NO YES	KIDNEY DISEASE: NO YES
BARRETTS ESOPHAGUS: NO YES	FREQUENT HEADACHE: NO YES	KIDNEY STONES: NO YES
BLEEDING DISORDER: NO YES	GOUT: NO YES	LUNG NODULE: NO YES
BLOOD TRANSFUSION: NO YES	HEARING LOSS: NO YES	MIGRAINES : NO YES
BRONCHITIS: NO YES	HEART ATTACK: NO YES	STOMACH UL: NO YES
CANCER: NO YES TYPE	HEART MURMUR: NO YES	VASCULAR DISEASE : NO YES
CARPAL TUNNEL: NO YES	HERPES: NO YES	PNEUMONIA: NO YES
CHROHNS DISEASE: NO YES	HEPATITIS: NO YES	RESTLESS LEG: NO YES
CHRONIC PAIN SYNDROME: NO YES	HIGH BLOOD PRESSURE: NO YES	RHEUMATIC DISEASE: NO YES
COLITIS: NO YES	HIV/AIDS: NO YES	SEIZURES: NO YES
COLON POLYPS: NO YES	HOARSENESS: NO YES	SINUS INFECTION: NO YES
DIABETES: NO YES	DRUG ABUSE: NO ES	STROKE: NO YES

SURGICAL HISTORY/ HOSPITALIZATIONS

ABDOMINOPLASTY: NO YES	RIGHT/LEFT CARPAL TUNNEL SURGERY: NO YES	LAPAROSCOPY:NO YES
ANGIOPLASTY: NO YES	CESAREAN SECTION: NO YES	NASAL SURGERY: NO YES
ANKLE/ FOOT SURGERY: NO YES	COLONOSCOPY: NO YES	PEDIATRIC EUSTACHIAN TUBES: NO YES
APPENDIX REMOVAL: NO YES	RIGHT/LEFT EYE SURGERY: NO YES	ORAL SURGERY: NO YES
BLADDER SURGERY: NO YES	BLADDER SURGERY : NO YES	RIGHT/LEFT SHOULDER SURGERY: NO YES
BLOOD TRANSFUSION: NO YES	GALLBLADDER: NO YES	SINUS SURGERY: NO YES
BREAST BIOPSY: RIGHT/LEFT NO YES	RIGHT/LEFT HAND/WRIST SURGERY: NO YES	SPLENECTOMY: NO YES
BREAST IMPLANTS: NO YES	HERNIA (TYPE): NO YES	SPINAL SURGERY: NO YES
TUBAL LIGATION: NO YES	PARTIAL/ TOTAL HYSTERECTOMY: NO YES	TONSILLECTOMY/ADENOIDECTOMY: NO YES
CARDIAC BYPASS SURGERY: NO YES	JOINT REPLACEMENT: NO YES	
CARDIAC CATHETERIZATION: NO YES	RIGHT/LEFT KNEE SURGERY: NO YES	

FAMILY HISTORY (Circle the relation or relations which applies to you)

DIABETES: Father Mother Sister Brother

TUBERCULOSIS: Father Mother Sister Brother

CANCER: Type_____ Father Mother Sister Brother

BLEEDING/ CLOTTING DISORDER: Father Mother Sister Brother

SEIZURES: Father Mother Sister Brother

HEART DISEASE; Father Mother Sister Brother

GALLSTONES Father Mother Sister Brother

STROKE: Father Mother Sister Brother

INFLAMMATORY DISEASE: Father Mother Sister Brother

"I declare that all the above information is complete and accurate"

Patient Signature_____ Date_____

General & Hand Surgery Of Southern Maryland
110 Hospital Rd, Suite 214
Prince Frederick, MD 20678
Phone: 410-535-7530 Fax: 410-535-0642

PATIENT REGISTRATION/INFORMATION FORM
PLEASE PRINT

***Patient's Name**: _____ **Today's Date**: ___/___/____
First Middle Last

***Date of Birth**: ____/____/____ ***Social Security Number**: ----------

***(CMS Requirements -Circle -1) Gender**: Male Female **Marital Status**: Single---Married---Widowed---Divorced

Ethnicity**--Hispanic—Non-Hispanic---Declined------Race**: White-- Black—Asian--Pacific Islander--Other Race

***Home Address**: _____ **City**: _____

State: _____ **Zip Code**: _____

***Billing Address (if different than above)**: _____

***Home Phone**: _____ **Cell Phone**: _____

***Primary Care Physician**: _____ ***Phone**: _____

Employer's Name: _____ **Employer's Phone**: _____

City: _____ **State**: _____ **Zip Code**: _____

Occupation: _____ **Jehovah's Witness**: Yes: ____ No: ____**(Required for transfusions)**

Primary Contact: _____ **Phone**: _____ **Relationship**:self—spouse-- parent

Secondary Contact: _____ **Phone**: _____ **Relationship**:self—spouse-- parent

Name of Custodial Parent/Guardian/ of Minor/ Mentally Challenged adult: _____

Primary Insurance Company: _____ **ID#**_____ **Group#**_____

Policy Holder's Name: _____ **DOB**: __/__/____ **SS#**: _____

Policy Holder's Employer's Name: _____ **Employer's Phone #**_____

Secondary Insurance Company: _____ **ID#**_____ **Group#**_____

Policy Holder's Name: _____ **DOB**: ___/____/_____ **SS#**: _____

Policy Holder's Employer's Name: _____ **Employer's Phone#**: _____

Tertiary Insurance _____ **ID#**_____ **Group #**_____

*****I declare that all the above information is complete and accurate.**

Patient's /POA/ Parent's Signature: _____ **** Date** ___/___/_____

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ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH

_____, _____ AND _____
PRIMARY INSURANCE SECONDARY INSURANCE TERTIARY INSURANCE

I DIRECTLY ASSIGN TO DR. HELMUT PFALZ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE FOR SERVICES RENDERED. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE:_____ **DATE**_____

WAIVER OF REFERRAL

IF MY INSURANCE COMPANY REQUIRES A REFERRAL OR AUTHORIZATION NUMBER PRIOR TO CONSULTATION WITH DR. HELMUT PFALZ, I ACCEPT RESPONSIBILITY FOR CHARGES FOR SERVICES RENDERED IF I DO NOT PROVIDE THIS REQUIREMENT.

NON-COVERED BENEFITS

IF PROCEEDURES AND PRE-EXISTING CONDITIONS ARE NOT COVERED BY MY INSURANCE, I ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED BY DR. HELMUT PFALZ.
NOTE: DEDUCTIBLES & CO-INSURANCE AMOUNTS WILL BE COLLECTED PRIOR TO THE OFFICE VISITS AND PRIOR TO SURGERIES.

COLLECTIONS

I UNDERSTAND THAT **FULL PAYMENT** ON OUTSTANDING BALANCES IS DUE WITHIN **90 DAYS** OR AN INTEREST CHARGE OF 21% WILL ACCRUE PER YEAR. I ALSO UNDERSTAND THAT DELINQUENT ACCOUNTS WILL BE SENT TO A COLLECTION AGENCY, ATTORNEY, OR SETTLED THROUGH **DISTRICT COURT** AT WHICH TIME I WILL BE RESPONSIBLE FOR ALL COURT COSTS, FILING FEES, INTEREST CHARGES, ATTORNEY FEES, AND COLLECTION FEES. ADMINISTRATIVE COSTS WILL BE ASSESSED AT $25.00 PER HOUR PLUS POSTAGE WHEN GENERAL & HAND SURGERY OF SO. MD. IS DIRECTLY IS ENGAGED IN LITIGATION OF ANY CASE.

CONSENT

I, _____, HEREBY GIVE MY CONSENT FOR DR. HELMUT PFALZ TO CONSULT AND PROVIDE MEDICAL OR SURGICAL TREATMENT TO ME, MY MENTALLY DISABLED AND/OR MINOR DAUGHTER OR SON, OR CUSTODIAN RELATIVE OR POA RELATION.

CANCELLATION OF APPOINTMENT
A 24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLED APPOINTMENTS. **ALL MESSAGES ARE DATED AND TIMED.** I UNDERSTAND THAT FAILURE TO COMPLY WITH THIS REQUIREMENT WILL RESULT IN A $25.00 CHARGE ASSESSED TO ME. THIS CHARGE MUST BE PAID **PRIOR** TO THE NEXT SCHEDULED APPOINTMENT.

_____**(INITIALS) I HAVE READ THE NOTICE OF PRIVACY PRACTICES. I AM AWARE THAT A COPY OF THIS DOCUMENT WILL BE GIVEN TO ME AT MY REQUEST.**
I HAVE READ AND AGREE TO COMPLY WITH THE ABOVE POLICIES.

SIGNATURE _____DATE: _____