BRIAN HASSLINGER, M.D., P.A.

PATIENT HISTORY AND INFORMATION

(ADULT)

DUE TO ALLERGY PATIENTS PLEASE DO NOT WEAR PERFUME OR COLOGNE TO YOUR APPOINTMENT

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Pharmacy: _____

Gender: M F SSN: _____ Referring or Family Physician: _____

Address/PO Box: _____ Marital Status: S M D W

City: _____ State: _____ Zip: _____

Phone No: Home: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

INSURANCE

Primary: _____ Secondary: _____

Effective Date: _____ Effective Date: _____

Member ID: _____ Member ID: _____

Group #: _____ Group #: _____

POLICY HOLDER

Who is the subscriber/member? (Please check one): ____self ____spouse ____parent ____other

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ SSN: _____

Gender: Male or Female

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Work number: _____

CONTACT INFORMATION Please list ALL family members who we can share patient's health information (this includes appointment times and emergency contacts). Notice: If left blank, only YOU can call this office for information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

*WHICH PHONE NUMBER MAY WE USE TO LEAVE YOU A MESSAGE? HOME WORK CELL

Dr. Brian Hasslinger, M.D., P.A.

Name: _____ Date: _____

CHIEF COMPLAINT: (Why are you here today?)_____

Review of Systems: Circle any symptoms you have. Write in additional symptoms

General: fatigue, dizziness, weakness, chills, night sweats, fainting
Head: headaches, (R, L, throbbing, dull, mid-facial, back, front, sides) head injury, migraine
Face: paralysis (R, L), rash, swelling, spasm
Eyes: itching, watery, double vision, poor vision, swollen lids
Ears: pain (R, L), hearing loss (R, L), ringing (R, L), fullness (R, L), drainage (R, L), itching (R, L), dizziness, recurrent infections
Nose: bleeding (R, L), congestion (R, L, constant, variable), runny nose, sneezing, postnasal drip (clear, green/yellow), sinus pain (R, L), loss of smell, recurrent sinusitis
Mouth: dental pain, sore tongue, bleeding, mass, ulcer, lesion, bad breath, dry mouth
Throat: sore throat, hoarseness, snoring, swallowing difficulty, lump, recurrent infections
Neck: pain, mass (R, L, midline), stiffness, soreness
Skin: rash, hives, lesions, itching, soreness
Allergy: pets, carpet, hardwood, season of symptoms

Have you or any of your family members (F) ever had any of the following conditions? Check all that apply:

	You	(F)		You	(F)		You	(F)
Acid Reflux			Emphysema			Liver Failure		
Anemia			Head Injury			Mitral Valve Prolapse		
Angina			Heart Attack			Psychiatric Problems		
Arrhythmia			Heart Failure			Reproductive Problems		
Arthritis			Hepatitis			Seizure Disorder		
Asthma			High Blood Pressure			Stroke		
Bleeding Problems			HIV/AIDS			Thyroid Disease		
Cancer			Intestinal Problems			Tuberculosis		
Chronic Bronchitis			Kidney Failure			Urinary Problems		
Diabetes			Leukemia/Lymphoma			Vascular Problems		
Other:								

Primary Care Physician: _____ **Marital Status: S M D W**

Do you have any pets please list how many and what type (cat/dog etc.) _____

What type of heat is in your home? _____ **Occupation/Retired from**: _____

Tobacco: Do you have a history of chew or smoking? (Circle one) No History Chew Smoke
What year did you start using tobacco/ if applicable when did you quit? _____
If you a current smoker, how many packs per day/week? _____

Alcohol: Do you have a history of alcohol use? (Circle one) No History No Current Beer/Wine Liquor
If you drink, how often and how much do you consume? _____

Drugs: Do you have any history of drug use? (Circle one) No History No Current List any usage: _____
_____

Surgical History
Have you ever had an ear, nose or throat surgery? (Circle one) yes no
Please list all Surgeries/Year: _____
_____
Do you have any known drug allergies and if so what type of reaction do you have? _____
_____

MEDICATION SHEET

Dr. Brian Hasslinger, M.D., P.A.

PATIENT NAME: _____ DATE: _____

If you have a medication list, bring it with you to your appointment. You don't need to fill out this form.

MEDICINE	DOSAGE	HOW MANY TIMES PER DAY	PRESCRIBING PHYSICIAN

FINANCIAL POLICY

REQUIRED PAYMENTS: CO-PAYS MUST BE PAID AT THE TIME OF SERVICE. We accept cash, check, money orders, MasterCard, Visa, Discover and American Express.

RETURNED CHECKS: There is a $40.00 fee for any checks returned from the bank.

MISSED APPOINTMENTS POLICY: A $25.00 fee may be charged to your account for any missed appointments. A $50.00 fee will be charged to your account for any missed Allergy Testing or Scheduled Surgeries and may result in NOT being rescheduled.

PAYMENTS: The balance on your statement is due and payable when the statement is issued and is past due if not paid within the 28-day billing cycle. All balances shown in the 91-120 day column must be paid IN FULL within 10 days of the statement date or the account will be transferred to the collection agency. You agree to reimburse Dr. Brian Hasslinger the fees of any collection agency which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses including reasonable attorney's fees we incur in such collection efforts.

ALLERGY PATIENTS: Because allergy treatment is an ongoing process, it is necessary for all of the above mentioned policies to be enforced and implemented, and therefore any patient balance must be PAID IN FULL BEFORE NEW ALLERGY VIALS WILL BE MIXED.

INSURANCES: We will bill any insurance that we participate with under contract. If we do not contract with your insurance we will collect payment in full at the time of service and provide you with a receipt for your use in seeking reimbursement from the insurance company. Although we provide, as a courtesy, benefit information on allergy testing and surgery procedures, it is ultimately YOUR responsibility as the policy holder to be aware of YOUR insurance benefits and requirements. Referrals required by your insurance are solely YOUR responsibility. Please be aware of your insurance company policies and requirements prior to any scheduled visit. With my signature below, I hereby authorize release of any relevant information necessary to process my claim to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to Brian Hasslinger M.D., P.A. I authorize Brian Hasslinger, M.D., P.A. and staff to contact my insurance company as an authorized person on my behalf for the purpose of payment. If your insurance company does not cover a service or procedure, you will be solely responsible for the bill.

By signing this Financial Policy I acknowledge that I have read and understood the above information and that I am considered the responsible party for payment of the medical account.

Patient/Guarantor Signature _____

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Brian Hasslinger may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Brian Hasslinger's notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DR. BRIAN HASSLINGER reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by calling our office at 240-964-4851 and requesting a revised copy be sent to you in the mail or asking for one at your next appointment.

With my consent, the office of Dr. Brian J. Hasslinger may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Dr. Brian Hasslinger may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

I agree with this form and I am bound by this agreement. By signing this form, I am consenting to Dr. Brian Hasslinger and his staff to use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon prior consent. If I do not sign this consent, Brian Hasslinger, M.D. may decline to provide treatment to me.

I hereby authorize Dr. Hasslinger to access/review lab work, radiology images and reports from Western Maryland Regional Health Center, Advanced Diagnostic Radiology or Potomac Valley Hospital for myself or my dependents.

Patient/Guarantor Signature _____

Patient Name _____ Date _____