Rochelle S. Hardy, M.D. **Patient Registration Packet**

7404 Executive Pl, Suite 502

Lanham, MD 20706

301-249-2700

**Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Sex: F / M Todays date: \_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Street Apartment/Unit | | | | Social Security number | |
| City State Zip Code | | | | | |
| Home Phone | Cell Phone | | | | Work Phone |
| Employer | | Your Email Address | | | |
| Employer address | | | Occupation/Job title | | |

|  |  |
| --- | --- |
| Street Apartment | Relationship |
| City State Zip Code | |
| Best contact number | |

**Insurance responsible Party Name: Date of Birth: Sex: F / M**

|  |  |
| --- | --- |
| Contact number | Relationship to patient |

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Primary insurance name | Secondary insurance name |
| ID/Policy number | ID/Policy number |
| Group number | Group number |

**INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Pharmacy address | Phone Number |

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**-AUTHORIZATION-**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Rochelle S. Hardy, M.D., to apply or benefits on my behalf for services rendered to me (or my minor child) and request that payment be made and sent directly to Rochelle S. Hardy, M.D.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me (or my minor child). I understand and agree that should my insurance deny my claim for any reason, I will pay such balance up demand. If my account is turned over for collection, I agree to pay reasonable collections and/or legal fees incurred as a result the undersigned agrees that should suit be filed, venue (location of suit) shall be Prince George’s County, Maryland, venue in any other jurisdiction being waived hereby.

I certify that the information I have reported with regard to my insurance coverage is correct, and I authorize the release of any information relating to my claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Signature (of patient or responsible party)

**Patient Registration Packet**

**Allergies to medications, X-Rays Dyes, insect stings or other substances? No Yes**

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| --- |
| If yes, please list allergies and reaction below  (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Your Medical History**

|  |
| --- |
| N Y N Y N Y N Y N Y  Hypertension Diabetes Heart disease Stroke Kidney disease  Mental illness Cancer - If yes, type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year diagnosed \_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Current Medications (PRESCRIPTION ONLY)/ dosage and frequency**

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| (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (7) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Surgical history**

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| Operation & Year  (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Women- GYN history**

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| --- |
| N Y  Last normal menstrual period \_\_\_\_\_\_\_\_\_\_\_ Last pap \_\_\_\_\_\_\_\_\_\_ History of HPV Contraception method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of: Pregnancies \_\_\_\_\_\_\_ Live births \_\_\_\_\_\_\_ Miscarriages\_\_\_\_\_\_\_ Abortions \_\_\_\_\_\_\_ Ectopic \_\_\_\_\_\_\_ |

**Family history**

|  |
| --- |
| Illness Which family members Illness Which family members  High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Patient Registration Packet**

**Screenings/ Prevention/ Preventive health**

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| --- | --- |
| When was your last:  Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cologuard \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  For men: PSA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Routine blood work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | N Y  Do you feel safe in your home  Do you wear seatbelts  Do you have a gun in your home  Do you have a “living will”  Do you have advanced directives |

**Social history**

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| --- |
| Marital status: Single Married (Spouse name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Divorced Widowed Separated  How many alcoholic drinks do you consume in 1 month \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?  N Y  Are you a current smoker If yes, how many cigarettes a day \_\_\_\_\_\_\_ and for how many years \_\_\_\_\_\_\_\_\_  Are you a former smoker If yes, what age did you start \_\_\_\_\_\_ and what age/year did you quit smoking\_\_\_\_\_  Are you a coffee drinker If yes, how many 8 ounce cups of coffee do you consume in a day \_\_\_\_\_\_  Are you sexually active If yes, form of contraception \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use any drugs If yes, what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you exercise If yes, how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Immunizations**

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| --- |
| When was your last:  Flu shot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tdap (Tetanus) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pneumonia vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingles vaccine #1\_\_\_\_\_\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_\_\_\_  COVID-19 vaccine #1\_\_\_\_\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_\_\_\_\_ Booster \_\_\_\_\_\_\_\_\_\_\_ (Pfizer, Moderna, Johnson & Johnson) |

**Any questions/ concerns for your first visit**

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||

**Patient Registration Packet**

**CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Use and disclosure of your protected health information:** Your protected health information will be used by only Dr. Hardy or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

**Requesting a restriction on the use or disclosure of your information:** You may request a restriction on the use or disclosure of your protected health information. Dr. Hardy may or may not agree to restrict the use or disclosure of your protected health information. If Dr. Hardy agrees to your request, the restriction will be binding to the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of consent:** You make revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Notice of privacy practices:** You have received the Notice of Privacy Practices with a complete description of how your protected health information may be used or disclosed.

**Reservation of right to change privacy practices:** Dr. Hardy reserves the right to modify the privacy practices outlined in the notice.

**I HAVE REVIEWED THIS CONSENT FORM AND GIVE MY PERMISSION TO DR. HARDY TO USE AND DISCLOSE MY HEALTH INFORMATION IN ACCORDANCE WITH IT.**

**Name of Patient (Please Print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient (or legal guardian)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**OFFICE GUIDELINES**

♦ Our office hours are: Monday, Tuesday and Thursday, 8:30a.m.-4:00p.m. (lunch 1-2) and Friday, 8:30a.m.-3:00p.m. (lunch 1-2). We are also available for phone calls on Wednesdays 8:30a.m.- 12:00p.m.

♦ We are now pleased to offer telemedicine appointments through DOXY.me!

♦ General questions, appointments, prescription refills, lab slips, and referrals will be done during office hours only.

♦ We **do not** Fax referrals

♦ If you need to cancel your appointment, it must be done 24 hours prior to your appointment time or you will be charged a **$50** fee. Call the office to cancel. Please understand that Dr. Hardy has reserved this time especially for you and another patient will not be able to be seen.

♦ Please remember that co-pays are due at the time of service or we will have to reschedule your appointment.

♦ Please note that if you have an outstanding balance on your account, 50% of that balance must be paid in order to be seen, unless it is determined that you have a medical emergency.

♦ As a service to you, we can fill out forms (disability documents, school forms, FMLA) for a fee of **$30** due at the time forms are received. Please allow a minimum of 3 business days for completion of the forms.

♦ A copy of your medical records can be provided to another doctor at no charge. A copy of your medical records can be provided to you with a **minimum** fee of **$30,** depending on the size of your chart.

♦ We accept cash, personal checks and credit card payments. There is a **$35** returned check fee.

♦ I give my permission for Dr. Hardy to be notified by any Maryland hospital of either my hospital admission/discharge or ER visits Yes No

***I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.***

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

**Signature of Patient (Parent) or Print name of Policy holder**

**Print name of Patient (Minor)**

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

**Date**

Revised 2/2022