Rochelle S. Hardy, M.D.
7404 Executive Pl, Suite 502
Lanham, MD 20706
301-249-2700

Patient Registration Packet

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

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

Street	Apartment	Relationship
City	State	Zip Code
Best contact number		

Emergency Contact Name: _____________________________________

Contact number	Relationship to patient

INSURANCE INFORMATION

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

Pharmacy Name: _____________________________

Pharmacy address	Phone Number

-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)

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

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

(1) ____ (5) ____

(2) ____ (6) ____

(3) ____ (7) ____

(4) ____ (8) ____

Surgical history

Operation & Year

(1) ____ (3) ____

(2) ____ (4) ____

Women- GYN history

Last normal menstrual period ___________ Last pap __________ History of HPV (N Y) ☐ ☐ 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	________________________________

Screenings/ Prevention/ Preventive health

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

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

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

1. ____

2. ____

3. ____

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_______________

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 Patient (Minor)

Print name of Policy holder

____

Date