Robert F. Hoofnagle, Jr., M.D., P.A.

Patient Information

Name: ____
Last First Middle

Address: ____
Street City State Zip

Home Phone: ____________ Work: ____________ Cell: ____________

Date of Birth: ____________ Sex: ________ Marital Status: ____________

Social Security Number: ____________________ Active Military: YES / NO

Email Address: ____

Emergency Contact: ____________________ Phone Number: ____________

Relationship to Patient: ____________________

Referring Physician: ____________________ Phone: ____________

Internist/Family Physician: ____________________ Phone: ____________

Race: ____________ Ethnicity: ____________ Preferred Language: ____________

Insurance Information

Primary Insurance: ____________________ Effective Date: ____________

Name of Policy Holder: ____________________ Holder DOB: ____________

Relationship to Policy Holder: ____________________

Secondary Insurance: ____________________ Effective Date: ____________

Name of Policy Holder: ____________________ Holder DOB: ____________

Relationship to Policy Holder: ____________________

I authorize the release of any medical information necessary to process my claims. I verify that all the above content is correct.

Signature: ______________________________ ***Date:*** ____________

Robert F. Hoofnagle, Jr., M.D., P.A.

Acknowledgement of Notice of Privacy Practices

I understand a copy of the Notice of Privacy Practices for this office can be made available at the time of my visit. I understand the Notice of Privacy Practices contains a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Notice of Privacy Practices at any time and I may contact this office at any time and obtain a current copy.

Please select one of the following:

_____ I wish to receive a copy of the Notice of Privacy Practices.

_____ I do NOT wish to receive a copy of the Notice of Privacy Practices. (I understand there is a copy in the office & may request a copy at any time.)

Accessibility of Your Healthcare Information

Please select one of the following:

_____You may speak with family/friends with regards to the treatment or payment of my medical care.

_____You may NOT speak with family/friends with regards to the treatment or payment of my medical care, unless I give you specific written permission at a later time.

Please sign to acknowledge that the above indicates your requests concerning your medical information.

______________________________	______________________
Patient Printed Name	***Patient Date of Birth***
______________________________	______________________
Patient/Guarantor Signature	***Date***
______________________________	
Relationship to patient (For minors/POA)	

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Robert F. Hoofnagle, Jr., M.D., P.A.

&

Baltimore Harford Surgical Center, L.L.C.
Financial Agreement

I, ______________________________ have requested treatment from Robert F. Hoofnagle, Jr. M.D. P.A. and/or Baltimore Harford Surgical Center, L.L.C. and have read and understand the following:

1. I am responsible for all co-payments, deductibles, and coinsurance for Robert F. Hoofnagle, Jr., M.D., P.A. and/or Baltimore Harford Surgical Center, LLC, as per the terms or contract with my insurance carrier.
2. If you are scheduled for a procedure, your insurance carrier(s) will be billed for both a surgical facility fee as well as a professional surgeon's fee. If you have a balance on your account you may possibly receive two bills: Robert F. Hoofnagle, Jr., M.D., P.A and/or Baltimore Harford Surgical Center, LLC.
3. All co-payments for office visits and out of pocket expenses for surgery must be paid at the time of service.
4. I am responsible for obtaining any and all required referrals for service. I will be responsible for any balances, penalties, etc. that are assessed should I not obtain a referral for services rendered.
5. I am responsible for all non-covered services. The office will do its best to inform me of any services that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
6. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
7. The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
8. The office does issue a fee for missed appointments. The current fees are $30 for office visits and $100 for scheduled surgery. I am responsible for payment of this fee if I fail to provide proper notification of cancellation for a scheduled appointment. To avoid this fee, I should call 24 hours prior to my scheduled appointment if I need to cancel or reschedule.
9. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution.
10. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt and all costs and expenses, including reasonable attorney's fees we incur in such collection efforts.

______________________________ ______________________________

Patient Signature ***Guardian Signature (If Minor/POA)***

____

Date

Robert F. Hoofnagle, Jr., M.D., P.A.

History and Intake Form
Please Do Not Leave Anything Unanswered

Today's Date: ______________________________

Patient Name: ______________________________ DOB: ______________

Address: ______________________________

Phone: ______________________ Cell: ______________________

Email: ______________________________

Past Medical History: (Please circle all the apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV / AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other: ______________________________

Medications: (Please list all current medications and dosages)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________
14. ______________________
15. ______________________
16. ______________________
17. ______________________
18. ______________________
19. ______________________
20. ______________________

Past Surgical History: (Please circle all the apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy (Both Breast)
Breast: Lumpectomy (Left Breast)
Breast: Lumpectomy (Right Breast)
Breast: Mastectomy (Both Breast)
Breast: Mastectomy (Left Breast)
Breast: Mastectomy (Right Breast)
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Hip (Both)
Joint Replacement: Hip (Left)
Joint Replacement: Hip (Right)
Joint Replacement: Knee (Both)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Right)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate (Prostatectomy): Prostate Biopsy
Prostate (Prostatectomy): Prostate Cancer
Prostate (Prostatectomy): TURP
Rectum: APR
Rectum: Lower Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer

Other: ______________________________

Urological Disease History: (Please circle all the apply)

Prostate Nodule
Cancer (Bladder)
Cancer (Kidney)
Cancer (Penile)
Cancer (Prostate)
Cancer (Testicular)
Elevated PSA
Hematuria
Hydronephrosis
Infertility
Priapism
Prostatitis
Renal Insufficiency
Sexual Dysfunction
Sexually Transmitted Disease
Undescended Testis
Urethral Stricture
Urinary Incontinence
Urinary Retention
Urinary Tract Infection

Other: ______________________________

Social History

Drug Allergies: ______________________________

Smoking Status: Never   Current   Former   Cigar smoker

If current smoker: How many packs a day? __________

Alcohol Use: None   less than 1 daily   1-2 drinks per day   3 or more drinks per day

Last Flu Shot? ________________ (approximate month and year)

Family History (Please list if any family members have the following)

Prostate Cancer: ______________________________

Bladder Cancer: ______________________________

Kidney Cancer: ______________________________

Kidney Stones: ______________________________

Renal Disease: ______________________________

Preferred Language: English   Spanish   Decline to Specify

Race: White   Black/African American   Asian   Decline to Specify

Ethnic Group: Hispanic / Latino   Non – Hispanic / Latino   Decline to Specify

Pharmacy Name and Zip Code: ______________________________

Primary Care Physician: ______________________________

Review of System (Please Circle all the apply)

Fever or chills
Unintentional weight loss
Nausea
Vomiting
Fatigue
Chest pain
Abdominal pain
Constipation
Problems with bruising

Problems with bleeding
Sleep apnea
Hearing loss
Muscle weakness
Joint pain
Glaucoma
HIV / AIDS
Hepatitis C
Allergy to adhesive

Allergy to Lidocaine
Artificial heart valve
Artificial joints
Blood thinners
Defibrillator
MRSA
Pacemaker
Premed prior to procedure
Pregnant or Trying