Montgomery Family Medicine Associates

2415 Musgrove Road, Suite 105
Silver Spring, MD 20904
301-989-0193

Patient Registration Form: 18 and over

If patient is a MINOR, please fill out form for 17 and younger

Patient's Last Name	First Name	Middle Initial	Age	Date of Birth	MALE TRANSGENDER *(Write pronoun)* FEMALE _____

Patient's Address	APT #	City	State	Zip Code

Primary # - HOME CELL (Circle One)	Secondary # - HOME CELL (Circle one)	**Email Address (important for portal access!)**

Social Security #	Patient's Employer	Employer Address	Patient's Occupation

Insurance Information

Insurance Company Name	Insurance Company's Address	City	State	Zip Code

Insurance's Subscriber (Last Name, First Name, Middle Initial)	ID Number	Group Number

Subscriber's Social Security	Date of Birth	MALE Transgender FEMALE *(Write pronoun)*	Relationship to Patient	Subscriber's Employer

2nd Insurance Company Name	2nd Insurance Company's Address	ID Number	Group Number

Personal/Emergency Contact Information

Marital Status	Spouse's Name (If applicable)	Spouse's Date of Birth	Spouse's Phone #

Emergency Contact Person	Relationship to Patient	Emergency Contact Person's Phone Numbers: HOME: CELL: WORK:

Emergency Contact Person's Address	APT #	City	State	Zip Code

Patient Allergies	How were you referred to Montgomery Family Medicine?

I, _____, hereby authorize Montgomery Family Medicine to apply for benefits on my behalf for services rendered to me (or my child) and request that payment be made by _____ Insurance Company and that payment be sent directly to Montgomery Family Medicine Associates, P.C. I understand that this, in no way, relieves me of my primary responsibility to pay for services rendered to me (or my child), and if my account is turned over for collection, I agree to pay any reasonable collection fees (25% is deemed reasonable). If a suit is filed, I agree to pay reasonable attorney fees (33.3% is deemed reasonable for court costs and other expenses incurred as a result of said collection). The undersign agrees that if a suit were to be filed, venue (location of suit) shall be in Montgomery County, Maryland. Venues in any other counties are 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 any claims for benefits, in order to process any claims 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. All of the information filled out above is completely and accurately filled out.

_____ Signature

_____ Relationship to Patient

_____ Print Name

_____ Date

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DISCLOSURE

Patient Name: _____ Date of Birth: _____

I authorize the providers and professional staff of Montgomery Family Medicine Associates, P.C. to leave messages regarding my medical information (lab results, reports, appointments, etc.) at the following phone numbers:

☐ Primary Phone _____

☐ Secondary Phone _____

Disclosure to Family/Friends:

☐ I ***DO NOT*** wish for Montgomery Family Medicine Associates to disclose any information concerning my care or treatment to individuals without my expressed written consent or legal authorization.

☐ I ***AUTHORIZE*** providers/staff to disclose information related to my care and treatment to the following named individuals:

Name	Relationship to Patient	Contact Phone Number
_____	_____	_____
_____	_____	_____

The authorization provided to the above persons are subject to the following limitations and/or restrictions:

_____

_____

_____

_____ _____

Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____

Printed Name of Signee Date

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Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

1. Check any of the following medical conditions that you have now or previously had:

___ A heart attack ____Plaque in the arteries of the heart (Coronary Artery Disease)
___ A stroke ____Plaque in the arteries of the neck (Carotid Artery Disease)
____Plaque in the arteries of the legs (Peripheral Arterial Disease)

___ High Blood Pressure (Hypertension)
If yes, any complications?
___ Kidney disease (as noted on bloodwork or finding of protein in urine)
___ Changes to the blood vessels of the eye(s) (Hypertensive Retinopathy)
___ Changes to the heart such as stiffening or thickening on echocardiogram (Diastolic Dysfunction or Left Ventricular Hypertrophy)

____ Diabetes ____ Prediabetes (Impaired Fasting Glucose)
If yes, any complications?
___ Kidney disease (as noted on bloodwork or finding of protein in urine)
___ Changes to the blood vessels of the eye(s) (Diabetic Retinopathy)
Please request the office of your Eye Doctor (Ophthalmologist or Optometrist) to send a copy of your Annual Diabetic Eye Exam to our office
___ Nerve problems, including numbness/tingling of the feet (Diabetic Neuropathy)
___ Uncontrolled high blood sugar (Hyperglycemia) _____Low blood sugar (Hypoglycemia)

____Chronic Kidney Disease (CKD) due to other condition *Specify:* _____
____ Fatty Liver Disease ____Gallstones ____Pancreatitis
____ High Cholesterol
____ Cancer *Specify:* _____
____ Autoimmune Disease *Specify:* _____
____Blood Clot in the Leg Veins (Deep Venous Thrombosis)
____Blood Clot in the Lung (Pulmonary Embolism)
____Asthma ____Chronic Obstructive Lung Disease (COPD) ____Emphysema
____Seizures or epilepsy ____Fainting (Syncope)
____Hypothyroidism ____Hyperthyroidism or Graves Disease
____Osteopenia ____Osteoporosis ____Broken Bone (Fracture)
____Depression ____Bipolar Disorder

Please list any other serious illnesses or medical conditions below:

_____
_____

2. When and by whom was your last physical exam? _____
3. Do you go to any other doctors/Specialists? *Note: You should have only one Primary Care Provider (PCP).*
If yes, please specify names and specialty (ies):

_____
_____
_____
_____

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Patient Name: _____ Date of Birth: _____

4. **ALLERGIES**

Are you sensitive or allergic to any drugs? ___ YES ___ NO

If yes, please specify each drug and reaction(s):

_____
_____
_____
_____
_____

5. **MEDICATION LIST**

Please list all medications that you are currently taking

Be sure to include any over-the-counter medications and vitamins/supplements

NAME	DOSE	FREQUENCY

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Patient Name: _____ Date of Birth: _____

MEDICATION LIST- CONTINUED

Please list all medications that you are currently taking

Be sure to include any over-the-counter medications and vitamins/supplements

NAME	DOSE	FREQUENCY

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Patient Name: _____ Date of Birth: _____

5. **MENSTRUAL HISTORY**

Age at onset _____ Interval between Periods _____ Duration _____

Date of last period _____ Anything unusual about your periods? _____

Any possibility of pregnancy? YES NO Currently Breastfeeding? YES NO

Be sure to mention any possibility of pregnancy or any current breastfeeding to your provider at the time of your appointment

6. **FAMILY HISTORY**

Has any blood relation (parent, sibling, child, other person related to you by blood) had:

Heart Attack or Stroke under the age of 55?	___ YES	___ NO
Sudden Death at a Young Age due to an Irregular Heart Rhythm? *Also known as Sudden Cardiac Death*	___ YES	___ NO
Blood clot in the legs or lungs (DVT OR PE)? *DVT = Deep Venous Thrombosis PE = Pulmonary Embolism*	___ YES	___ NO
Aneurysm in the Brain? *Also known as Intracranial Aneurysm or Berry Aneurysm*	___ YES	___ NO
Medullary Thyroid Cancer?	___ YES	___ NO
Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2)?	___ YES	___ NO

This is a hormonal cancer syndrome. If you have a family history of MEN2 or medullary thyroid cancer, you cannot take GLP1 agonist medications such as Wegovy, Ozempic, Mounjaro, or Zepbound. Please note that there are various types of thyroid cancer, with medullary being relatively less common.

Continued on next page

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Patient Name: _____ Date of Birth: _____

7. **FAMILY HISTORY - CONTINUED**

Please include blood relatives only

Family Member	Living / Deceased *(Circle One):*	Current Age or Age at Death	High Blood Pressure	Diabetes	Colon Cancer *(Age at diagnosis):*	Breast Cancer *(Age at diagnosis):*	Autoimmune Disease *(Specify):*	Mental Health Conditions *(Specify):*	Other Major Medical Conditions *(Specify):*
Parent 1 *Specify*:	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
Parent 2 *Specify*:	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
Sibling 1 *Specify*:	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
Sibling 2 *Specify*:	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐_____	_____
Child 1 *Specify*:	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
Child 2 *Specify*:	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
***Specify Other*:**	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
***Specify Other*:**	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
***Specify Other*:**	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____
***Specify Other*:**	**L / D**	_____	☐	☐	☐ _____	☐ _____	☐_____	☐ _____	_____

8. **SOCIAL HISTORY**

1. Do you smoke cigarettes or use nicotine e-cigarettes (i.e. vaping) ___ YES ___ NO ___ FORMERLY

   If current use, how often? ___ Monthly ___ Weekly ___ Daily
   If ever smoked, how many packs per day? _____ For how many years? _____
   If previously smoked or used e-cigarettes, quit date? _____

2. Do you drink alcoholic beverages, including beer, wine, or spirits/liquor? ___ YES ___ NO

   If yes, how often? ___ Monthly ___ Weekly ___ Daily
   How many drinks per occasion? _____

3. Do you use any other substances, including medical marijuana or other drugs for non-medical purposes?

   If yes, please provide details: _____
   _____
   _____

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9. **HOSPITALIZATION HISTORY**

Reason/Condition	Date Admitted	Date Discharged

10. **SURGICAL HISTORY**

Type of Surgery	Date	Complications, if Any

Montgomery Family Medicine Associates
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Patient Name: _____ Date of Birth: _____

11. **HEALTH MAINTENANCE**

1. Last Colonoscopy – Result _____ Date _____
2. Last Mammogram – Result _____ Date _____
3. Last DEXA Scan – Result _____ Date _____
4. Last Pap Smear – Result _____ Date _____
5. Last Lung Cancer Screening CT – Result _____ Date _____
6. Hepatitis C Blood Test – Result _____ Date _____

Which immunizations, vaccinations, or inoculations have you had?

Vaccine	**Date Given**	**Vaccine**	**Date Given**
Td	_____	PCV20 (New Pneumonia)	_____
Tdap	_____	PCV21 (New Pneumonia)	_____
HPV Dose 1	_____	PCV13 (Old Pneumonia)	_____
HPV Dose 2	_____	PPSV23 (Old Pneumonia)	_____
HPV Dose 3	_____	RSV Vaccine	_____
Hepatitis B Dose 1	_____	MMR Dose 1	_____
Hepatitis B Dose 2	_____	MMR Dose 2	_____
Hepatitis B Dose 3	_____	BCG	_____
Shingrix (New Shingles Vaccine) Dose 1	_____	Last Flu Shot	_____
Shingrix Dose 2	_____	Last COVID-19 Shot	_____
Zostavax (Old Shingles Vaccine)	_____	Other (*Specify*)	_____

ALL PATIENTS OVER 40 WITH THE FOLLOWING RISK FACTORS

Coronary Artery Disease/Diabetes **AND/OR** **High Cholesterol plus Hypertension/Smoking**

1. Stress Test (regular or nuclear) Date _____
2. Peripheral artery screening test (sonogram of leg arteries) Date _____
3. Carotid artery disease screening test (sonogram of neck arteries) Date _____
4. Coronary artery calcium score (CT scan of coronary arteries) Date _____

ALL MALE PATIENTS OVER 65 WITH ANY HISTORY OF SMOKING

1. Abdominal Aorta Aneurysm Screening YES NO If yes, provide date _____

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Patient Name: _____ Date of Birth: _____

ATTESTATION

My signature below indicates that the above information is accurate and complete to the best of my knowledge.

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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PREVENTATIVE/PHYSICAL APPOINTMENT

Annual Preventative Visits (APVs, formerly known as Physicals) are for Prevention and Screening. This includes age-appropriate health maintenance, such as vaccines and cancer screenings. We also order routine laboratory tests and EKGs as indicated. If you would like routine screening for sexually transmitted infections, please inform your provider at the time of your appointment.

Please schedule your APV when you are well.

As per insurance guidelines, APV are not for addressing acute problems.

If for some reason you have a new problem that arises after you have scheduled your APV, please call to CHANGE your appointment to a problem-based visit, and reschedule your APV.

Please note that your first appointment will be a problem-based visit and not an APV.

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/legal guardian) Relationship to Patient

_____ _____
Print Name Date

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OFFICE POLICIES - GENERAL

Welcome to Montgomery Family Medicine Associates, P.C. We are pleased that you have chosen us to be your primary care practice. Below are some important office policies that we would like you to review.

MISSED APPOINTMENTS

The office requires a 24hr notice for all appointment cancellations during our office hours. If this courtesy is not extended to the office, the fees listed below will be imposed:

- $30 for regular missed appointments
- $50 for missed appointments on Saturdays and any appointments after 3:30pm or before 8:30am (including ECHO & VASCULAR studies)
- $100 for missed appointments for Annual Preventive Exams

This fee is your responsibility and will not be covered by your insurance. Should you incur this fee, it must be paid by your next office visit. **Please do not call our answering service to cancel appointments.** When making appointments, please provide a valid phone number where you can be reached directly to confirm your appointments.

CO-PAYMENTS

Your co-payment is a fee imposed by your insurance company. Your co-pay must be paid at the time of your visit. If you have to be billed for your co-pay a surcharge of $10 will be added to each missed co-pay (to cover for billing costs).

PRESCRIPTION REFILL POLICY

At the time of your office visit, please remember to have your provider refill any prescriptions you need to last you until your next scheduled visit. We monitor most chronic conditions every 6 months and send 90 day supplies plus 1 additional refill. We request you not to call or send portal messages with refill requests except under exceptional circumstances. For medication safety reasons, we do not accept refill requests from pharmacies. **Please note:**

- No prescription refills can be done by the Answering Service on-call provider
- **NO CONTROLLED DRUGS** can be prescribed by covering providers. Under extenuating circumstances, the covering provider may be able to prescribe a small quantity of medication to last you until your usual provider is available.

PORTAL POLICY

We highly encourage all patients to sign up for the portal. You will receive a link to the email address you provided after your first visit. If you do not see it, please check your Spam folder.

Please be aware that if you are being seen by a Physician Extender (i.e. PA or NP), you may receive a portal message from the Extender or supervising physician after your visit, with additional recommendations.

DELINQUENT ACCOUNT/RETURNED OR BOUNCED CHECKS

Payments must be made at the time of service. This includes payments for the current visit and any balance due. Returned checks are subjected to a **$37.50 returned check fee** and suspension of check writing privileges. You may **NOT** be seen for non-emergency care until your account is paid in full. If you are unable to settle your account, payment arrangements can be made. If your payments are not made as promised, we reserve the right to pursue recovery through legal action and/or you may be discharged from Montgomery Family Medicine Associates, P.C. All patients will be responsible for legal fees (25% or account balance, court costs, and other expenses incurred as a result of collections).

INCLEMENT WEATHER POLICY

Please call the office's main phone line at **301-989-0193** before leaving your home to see if the office is open on time. You will hear a recorded message informing you of any change in our hours. If you do not hear this recording, you may ask the Answering Service.

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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STATEMENT OF COMMITMENT TO MAINTAIN A RESPECTFUL ENVIRONMENT

Our clinic is committed to maintaining a safe, respectful, and inclusive environment for patients, staff, and visitors. We reserve the right to terminate the patient-provider relationship and discharge a patient for conduct that is disruptive, threatening, abusive, discriminatory, harassing, or otherwise interferes with the provision of care, including but not limited to the use of hateful or discriminatory language directed at staff, providers, or other patients, consistent with applicable laws and ethical obligations. Discriminatory language may include, but is not limited to, derogatory, demeaning, hostile, or exclusionary remarks, made verbally and/or in written form, based on a person's race, color, ethnicity, national origin, ancestry, religion, creed, sex, gender, gender identity or expression, sexual orientation, age, disability, medical condition, genetic information, marital status, pregnancy, veteran or military status, socioeconomic status, or any other characteristic protected by applicable federal, state, and/or local law(s).

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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OFFICE CONTROLLED SUBSTANCES POLICY

Due to new regulations in Maryland, it's harder to get prescriptions for certain pain medications, sleep aids, and attention-deficit hyperactivity disorder (ADHD) drugs. We're still prescribing these medications to patients who are already taking them to avoid issues like withdrawal from abruptly stopping them. At the same time, we are carefully following both state and federal rules.

Controlled Substance Medications include (but are not limited to):

Opioids (e.g. oxycodone, hydrocodone, oxycodone-acetaminophen/Percocet)
Benzodiazepines (e.g. lorazepam/Ativan, alprazolam/Xanax, clonazepam/Klonopin)
Z-drugs (e.g. zolpidem/Ambien, eszopiclone/Lunesta, zaleplon/Sonata)
Stimulants (e.g. dextroamphetamine-amphetamine/Adderall, lisdexamfetamine/Vyvanse, methylphenidate/Ritalin)

Risks of these medications include:

Drowsiness, falls (especially for people over 65), driving impairment, overdose, and dependence.
They can also affect your heart rhythm and interfere with other medications.

Managing Your Existing Controlled Substance Medication:

Safety: We'll ask you to count your pills and get a refill for only the amount needed. This helps keep your home safe. Per regulations, opioid refills (except buprenorphine and tramadol) are for 30 days max and require an in-office visit. Other controlled medications depend on the medication and can be up to 90 days max.

Appointments: To get a refill, you'll need a scheduled appointment. We can accommodate certain virtual appointments. In-office visits are required at least twice a year. It is your responsibility to schedule each appointment at least 5-7 days before you run out of medication.

Running Out Early: If you run out before your appointment, call us during business hours for a short-term supply to last until your next appointment. This should happen rarely.

Controlled Substance Agreement: You'll need to sign an agreement acknowledging potential drug screenings and other safety items. This agreement is renewed yearly.

Safety Measures: If there are safety concerns, your provider may prescribe a lower dose, wean you off the medication, or suggest a safer alternative. We have expertise in Addiction Medicine and are glad to help you taper off.

Specialist Referrals: If you disagree with your provider's decision, you can seek a second opinion from a Pain Management or Psychiatry specialist. Your provider may also recommend this Specialty consultation.

New Prescriptions:

We won't start new prescriptions for opioids, benzodiazepines, or Z-drugs unless you need them for a short time for a specific reason (like severe pain due to an injury, or situational anxiety due to a transient or rare event). We may or may not start a stimulants for ADHD on a case-by-case basis.

If you're prescribed a new controlled substance medication, we will fill it for up to 30 days. You will need to schedule appointments before you run out of medication. We will make a plan together for safe long-term management of your condition.

Thank you for your understanding. Maintaining compliance with regulatory requirements allows us to sustainably provide safe, effective care.

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____
Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____
Printed Name of Signee Date

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Use & Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The education pamphlet entitled "Notice of Privacy Practices" provides information about how Montgomery Family Medicine Associates, P.C. may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Program and Accountability Act of 1996 (HIPAA). You will have access to this pamphlet at the time of your first appointment.

Our notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

In addition, the terms listed in our Notice of Privacy Practices have been revised or amended, as follows:

If you do not confirm via text message (preferred method for appointment confirmation), we will call you one to three (1-3) business days prior to your appointment and leave a message on your behalf, with the date and time of your upcoming appointment.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

My signature below indicates that I have read, acknowledged, and will adhere to the above policies:

_____ _____

Signature of Patient (or Parent/Responsible Party) Relationship to Patient

_____ _____

Printed Name of Signee Date

CONSENT FOR USE & DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Montgomery Family Medicine Associates, P.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services, its agents and/or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services, I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements. As a reminder, a surcharge of $10.00 will be added to each missed co-pay (to cover billing costs if we have to bill you for your co-pay).

_____ _____

Signature of patient (or parent/legal guardian) Relationship to patient

_____ _____

Print Name Date

For more information or to report a problem: If you have any questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health & Human Services. There will be no retaliation for filing a complaint.