JHCP General Surgery at Foxhall

- ☐ Peter E. Petrucci, M.D., F.A.C.S.
- ☐ Michael L. Palmer, M.D., F.A.C.S.
- ☐ Martin G. Paul, M.D., F.A.C.S.
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JOHNS HOPKINS MEDICINE

ADD'L PHYSICIANS

Please provide demographic information below which can be used as means to contact you or your designated representative.

PATIENT'S NAME: FIRST	MI	LAST	**SEX** ☐M ☐F	**BIRTH DATE**	**AGE**

HOME ADDRESS: STREET	(APARTMENT #)	CITY	STATE	ZIPCODE	**COMMUNICATION PREFERENCE** ☐Home ☐Work ☐Cell

PATIENT HOME PHONE	**PATIENT WORK PHONE**	**PATIENT CELL PHONE**	**PATIENT EMAIL**

INTERPRETER NEEDED ☐YES ☐NO	**LANGUAGES SPOKEN** ☐ENGLISH ☐OTHER: _____	**U.S. CITIZEN** ☐Yes ☐No	**COUNTRY OF BIRTH**

PATIENT'S SOCIAL SECURITY NO.	**MARITAL STATUS** ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED ☐DOMESTIC PARTNER

MOTHER'S MAIDEN NAME	**RELIGIOUS PREFERENCE**	**RACE** ☐AMER INDIAN ☐ASIAN ☐BLACK ☐OTHER ☐PACIFIC ISLE ☐UNKNOWN ☐WHITE

ETHNICITY ☐HISPANIC, LATINO, SPANISH ORIGIN ☐NOT HISPANIC, LATINO, SPANISH ORIGIN ☐DECLINED TO ANSWER	**PHARMACY PHONE**

EMPLOYER NAME / ADDRESS	**STATUS** ☐FULL TIME ☐PART TIME ☐OTHER:	**EMPLOYMENT DATE**

PRIMARY CARE PHYSICIAN	ADDRESS	PHONE
GASTROENTEROLOGIST	ADDRESS	PHONE
CARDIOLOGIST	ADDRESS	PHONE

EMERGENCY CONTACT / RELATIONSHIP	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**

GUARANTOR/PERSON RESPONSIBLE FOR BILL ☐SELF, SKIP TO PRIMARY INSURANCE ☐SPOUSE ☐PARENT ☐OTHER	GUARANTOR NAME / RELATIONSHIP	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER	PHONE

PRIMARY INSURANCE COMPANY	MEMBER ID#	GROUP #	EFFECTIVE DATE

INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	DATE OF BIRTH	SOCIAL SECURITY NO.

SUBSCRIBER'S EMPLOYER	PHONE	RELATIONSHIP TO PATIENT ☐SELF ☐SPOUSE ☐OTHER

SECONDARY INSURANCE COMPANY	MEMBER ID#	GROUP #	EFFECTIVE DATE

INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	DATE OF BIRTH	SOCIAL SECURITY NO.

SUBSCRIBER'S EMPLOYER	PHONE	RELATIONSHIP TO PATIENT ☐SELF ☐SPOUSE ☐OTHER

I certify that the information I have reported above is accurate and correct.

PATIENT, GUARDIAN, OR PARENT SIGNATURE (IF UNDER 18) **DATE**

Today's Date _____

CONTACT INFORMATION

Patient First Name	MI	Last Name	Age	Date of Birth	Sex

Occupation:

Primary Language (circle one)
English Spanish Other_____

Do you have an advance Directive (Living Will)?
No _____ Yes _____ *If yes, a copy should be placed on file in your medical record.*

Legal Representative's Name & Contact Number:

Primary Care Physician | **Date Last Seen**

Cardiologist | **Date Last Seen**

Names of Other Physician(s)
_____
_____

PRESENT ILLNESS / CONDITION

What type of exam do you need / What brings you in?

What are your symptoms (include body part) / date of onset?

Please select all tests you've had for this problem:

☐ MRI ☐ CT Scan ☐ Ultrasound
☐ MRE ☐ Endoscopy ☐ Mammogram
☐ X Ray ☐ Colonoscopy ☐ Biopsy

Other _____

YOUR MEDICAL HISTORY (If no box is checked, none is assumed.)

Cardiac / Heart Disease
☐ None
☐ Atrial Fibrillation
☐ Chest Pain
☐ Cong. Heart Failure
☐ Heart Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Pulm. Hypertension
☐ Pacemaker / ICD
☐ Rhythm Disturbances
Specify:_____

Gastrointestinal
☐ None
☐ Crohn's Disease
☐ Inguinal (Groin) Hernia
☐ Umbilical Hernia
☐ Incisional Hernia
☐ Hernia: Other_____
☐ Gallbladder Pain
☐ GERD / Gastric Reflux
☐ Intestinal Obstruction
☐ Liver Disease
☐ Intestinal / Gastric Ulcers
☐ Other _____

Genitourinary
☐ None
☐ Kidney Disease
☐ Kidney Stones
☐ Prostate/Testicle Disorder
☐ Urinary Tract Infection
☐ Difficulty Urinating

Mental Health
☐ None ☐ Alzheimer/Dementia
☐ Anxiety ☐ Chem. Dependency
☐ Depression ☐ Epilepsy / Seizure
☐ Migraines ☐ Learning Disability
☐ Stroke ☐ Other: _____
☐ Panic Attack

Respiratory
☐ Asthma ☐ None
☐ Bronchitis ☐ COPD
☐ Emphysema ☐ CPAP
☐ Sleep Apnea

Vision
☐ None ☐ Cataract(s)
☐ Glasses ☐ Glaucoma
☐ Contacts ☐ Legally Blind
☐ Macular Degeneration

Bleeding / Circulation
☐ Anemia ☐ None
☐ Blood clots ☐ Sickle Cell
☐ Bleeding Tendency
☐ Poor Circulation

Endocrine
☐ None
☐ Diabetes
☐ Thyroid Problems / Goiter
☐ Adrenal Disease

Implantable Devices
☐ None ***Please bring card!***
☐ Dialysis Port / Pump
☐ Other Port / Pump
☐ Pacemaker / Oth._____

Musculoskeletal
☐ None ☐ Muscular Dystrophy
☐ Arthritis ☐ Multiple Sclerosis
☐ Polio ☐ Back Pain
☐ Neck Pain ☐ Uses Wheelchair/Walker

Cancer
☐ None
☐ Type: _____
☐ Chemo Radiation

Skin
☐ None
☐ Rash _____
☐ Skin Mass/Lesion

Hearing
☐ None
☐ Hearing Loss
☐ Hearing Aid Worn

Infectious Disease
☐ None ☐ MRSA ☐ Hepatitis
☐ C-Diff ☐ TB Type ___
☐ HIV ☐ VRE ☐ Mono

Have you ever been hospitalized for any of the above conditions? If yes, please briefly explain including dates, hospital name, city, and state.

SURGICAL HISTORY (please include Year Surgery was completed)

☐ No Prior Surgery
☐ Angioplasty _____
☐ Appendectomy _____
☐ Breast Biopsy _____
☐ Colon/Intestinal _____
☐ D & C _____
☐ Gallbladder _____
☐ Heart Surgery _____
☐ Pacemaker _____
☐ Hemorrhoidectomy _____
☐ Hernia _____
☐ Hysterectomy _____
☐ Kidney Removal _____
☐ Mastectomy _____ L☐ R☐
☐ Other_____ Year _____
☐ Prostate _____
☐ Spine (Back/Neck) _____
☐ Splenectomy _____
☐ Joint Replaced _____ L☐ R☐
☐ Other_____ Year _____

Continued on Page 2

FAMILY HISTORY (Only Close Blood Relatives)

Please specify if the person is on maternal/paternal side & relationship

☐ Anesthesia Complications:	Mat☐ Pat☐ Rel_____	☐ Heart Disease:	Mat☐ Pat☐ Rel_____
☐ Bleeding Disorders:	Mat☐ Pat☐ Rel_____	☐ High Blood Pressure:	Mat☐ Pat☐ Rel_____
☐ Cancer: _____	Mat☐ Pat☐ Rel_____	☐ Kidney Disease:	Mat☐ Pat☐ Rel_____
☐ Cancer: _____	Mat☐ Pat☐ Rel_____	☐ Other:_____	Mat☐ Pat☐ Rel_____
☐ Diabetes:	Mat☐ Pat☐ Rel_____	☐ Other:_____	Mat☐ Pat☐ Rel_____

ALLERGIES

Irritant	Allergic?	Reaction
Ex. Shellfish	☐ *Yes* ☐ *No*	*Rash*
Latex	☐ Yes ☐ No	
Adhesive	☐ Yes ☐ No	
Iodine	☐ Yes ☐ No	
Meds & Other	Yes / No	If yes, please list below and describe
_____		
_____		
_____		
_____		
_____		
_____		

CURRENT MEDICATIONS (include vitamins, supplements, etc.)

Medication Name	Dose	Fequency
Ex. Coumadin	*5mg*	*daily*

YOUR SOCIAL HISTORY

If no, check appropriately. If yes, comment as indicated.		***Comments***
Have you had a problem with anesthesia including malignant hyperthermia or difficult intubation? (If N/A, please note in comments)	☐ Yes ☐ No	
Do you exercise regularly?	☐ Yes ☐ No	Low☐ Moderate☐ Active☐
Are you short of breath after walking up two flights of stairs?	☐ Yes ☐ No	
Do you currently smoke?	☐ Yes ☐ No	# packs per day ____ for # years____
Are you an ex-smoker?	☐ Yes ☐ No	When did you stop?
Do you currently use smokeless tobacco (chew, snuff, etc.)?	☐ Yes ☐ No	What type & how often?
Have you previously used smokeless tobacco?	☐ Yes ☐ No	What type when stopped?
Do you drink alcoholic beverages?	☐ Yes ☐ No	How often per week?_____ How many?_____
Do you use any street drugs?	☐ Yes ☐ No	
Have you ever had a blood transfusion?	☐ Yes ☐ No	What year(s)?
Do you have objections to receiving blood transfusions?	☐ Yes ☐ No	
Any religious or cultural practices we should know about?	☐ Yes ☐ No	
Females Only: Is there any chance you could be pregnant?	☐ Yes ☐ No	Last menstrual period?

Other Comments? _____

Patient signature _____ Date: _____

If legal guardian, relationship to patient _____

Internal Use Only (Please Leave Space Blank)

Surgeon's Notes:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Medical Record #: _____

Birth Date: _____

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____, confirm that I am the representative for the patient
(insert your name)
based on the following relationship to the patient:

_____
(state relationship, for example—parent, spouse, guardian)

Representative's Signature: _____ **Date:** _____
(Required)

Address: _____ **Phone:** _____

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JOHNS HOPKINS COMMUNITY PHYSICIANS GENERAL CONSENT FORM

This form serves three purposes: (1) It says that I want Johns Hopkins Community Physicians to treat me; (2) It says that Johns Hopkins Community Physicians can be paid directly by my health plan; and that, in some cases, I may have to pay for my treatment. (3) It says that I agree to allow Surescripts, an electronic prescribing network, to release my medication refill history to Johns Hopkins Community Physicians.

1) CONSENT FOR TREATMENT

I, or the person who represents me, consent to have Johns Hopkins Community Physician provide the medical care that the doctor or other health care people who are taking care of me say I need. Unless it is an emergency, they will describe this medical care and any significant risks that may be involved in my care.

2) WHO WILL PAY FOR MY CARE

I know that Johns Hopkins Community Physicians will bill my health plan for the care that I receive. I agree that payment from my health plan will go directly to Johns Hopkins Community Physicians.

I know that under Maryland Law Johns Hopkins Community Physicians can send me a bill in any of these cases;

1) When I choose to have care that my health plan covers but I do not get a needed referral or an approval from my health plan.
2) When I choose not to use my health plan and agree to pay for the care myself.
3) When my health plan does not include Johns Hopkins Community Physician for the care I want or need and I agree to pay for the care myself.
4) When I receive care that is not covered under my health plan.

I know that I must pay for any co-payment or other part of the bill that my health plan says I must pay. I know I may need to pay this before I am treated.

3) ELECTRONIC PRESCRIBING

I authorize Surescripts, and electronic prescribing network, to release my medication refill history to Johns Hopkins Community Physicians for the purpose of continued treatment.

Signature: _____ Date: _____

For health care agent / guardian / surrogate / parent (circle one), I, _____ am the representative for the patient as circled above.

Representative's signature: _____ Date: _____

Address: _____

_____ Phone#: (_____) _____

_____ _____
Witness Signature / Agency Representative **Date**

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STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

- **NOT TO BE USED IN CONNECTION WITH HEALTH INFORMATION FROM SUBSTANCE ABUSE TREATMENT OR MENTAL HEALTH PROGRAMS.**

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Patient Name: _____
(first) (m. initial) (last)

Address: _____
(street address) (city) (state) (zip code)

Medical Record #: _____ **Birth Date:** _____

For this authorization, "My Health Information" means any and all information relating to my course of examination and treatment.

I authorize Johns Hopkins to discuss My Health Information with:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Phone #: _____ **Phone #:** _____

For general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, Johns Hopkins will not disclose My Health Information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient: _____ **Date:** _____

Late Patient Policy

PURPOSE: To define clear directions for the staff and doctors to follow as to when a patient is considered late and must be rescheduled and when a patient is considered on time and will be seen.

RATIONALE: Reserved appointment time in any surgical office is limited and valuable. It is extremely important that all patients honor their reserved office appointments. Failure to do so deprives our other patients from receiving needed surgical care in a timely fashion .One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible. If we are running late due to an unanticipated emergency, we will make every effort to accommodate you and will strive to keep you updated.

DEFINITION: A late patient is defined as being more than 30 minutes late for their scheduled appointment.

PROCEDURE:

1. If the patient shows up more than 30 minutes after their scheduled appointment time, then the receptionist will inform the patient that they have missed their appointment.

2. The receptionist will try to help the patient by looking at that doctor's schedule for the day to determine if they can work the patient in at a later time that day. It is important to tell the patient that their existing time slot is gone and you are looking to see when they can be seen that day. The receptionist has authority to use judgment as to the best time to manipulate the doctor's schedule.

3. If it is impossible to manipulate the schedule the receptionist should reschedule the appointment for a later date unless it is an urgent appointment.

4. If the patient insists that they must be seen that day, and that their condition is urgent it will be up to the medical assistant to determine the urgency of the visit and schedule appropriately. If it can wait until a later date, the medical assistant will inform the receptionist that it can be rescheduled. If the patient is persistent in their request to be seen immediately a message should be given to the medical assistant who can coordinate that decision with the doctor.

5. If the patient is 30 or fewer minutes after their appointed time this will be considered an on-time visit and the doctor will see the patient as if they were ontime. If this occurs at the lunch hour it will be up to the individual doctor to determine if they can see the patient.

6. We will continue to track these incidences to determine if it is a chronic occurrence for a particular patient. If it has happened three or more times it will be up to the office manager and the doctor to determine the next course of action for the patient.

Photos in the Electronic Medical Record

What is the purpose of entering my photo into the electronic medical record?

Patient safety is our number one concern. Many patients have same/similar names and birthdates. Your photo helps us make sure that the care we provide and document is completed on the correct patient.

- Photos help the staff member verify that they are viewing and documenting your care in your chart.
- Photos help providers and staff recall the interactions they had with you, especially when communicating with you in MyChart. This helps prevent staff from confusing you with another patient.
- Seeing your photo helps to generate recall so that staff more easily remember your story.
- Photos help prevent someone else from using your identify to commit insurance fraud.

Is the photo required?

No. You may refuse to have your photo taken, but this is an important step in making sure that we provide safe care. The Johns Hopkins network is large, and we have many patients with similar names and birthdates. We strongly encourage all patients to have an identification photo in their electronic medical record.

How often will my photo be taken?

Adults: After the initial photo is taken, an updated photo will be taken at each new decade of life (e.g., 40 years of age, 50 years of age, etc.) An updated photo will also be taken if your physical appearance changes drastically (e.g., Weight change, hair change, etc).

Children: After the initial photo is taken at 5 years of age, an updated photo will be taken every other year on the odd year of age (e.g., 7 years of age, 9 years of age, etc) An updated photo will also be taken if their physical appearance changes drastically.

What happens to my photo once it is taken?

The photo is uploaded into the electronic medical record. Photos are not stored on the device or the computer. Staff will never be able to retrieve a previous photo, share it, or store it on a device.

How secure is my photo?

The photo is stored within your medical chart and is as secure as your medical record

Is a photo ID still required when picking up prescriptions or arriving for appointments?

Yes. You still need to present a valid photo ID.