Mian Family Medicine, LLC

NEW PATIENT BRIEF INTAKE FORM

Patient Name: ________________________________ DOB: __________

Past Medical History: **Last PCP Name: ______________________**

1.
2.
3.
4.
5. Specialists (do you see any specialists):

Past Surgical History with date of surgery:

1.
2.
3.
4.

Allergies: None or list allergies to medications or list any reactions to medications below:

1.
2.
3.

Medications: list name, dose and how often medication is taken

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

Social History: Single or Married and/or Children: ____ son (s) and/or ____ daughter

Tobacco use _____ yes _______ no

Alcohol use _____ yes _______ no

Vaccinations: (list date, location or "refuse to get"):

1. Influenza vaccine
2. Pneumonia Vaccine:
3. Tetanus:

Family History:

1.
2.
3.
4.

Patient Signature:______________________ Date: ________ Staff Initials: _______

Mian Family Medicine, LLC
9114 Philadelphia Road, Suite #214
Baltimore, MD 21237

Privacy Policy

Acknowledgement of Receipt of Notice of Privacy Practices.

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices, or I have previously received a copy and decline a copy for this visit.

____
(Patient's Printed Name)

________________________________ ____/____/______
(Patient's Signature) (Date)

If signed by a parent, guardian, or legal representative:

____
(Relationship to Patient)

________________________________ ____/____/______
(Signature) (Date)

If you have not received a copy of this notice please ask the receptionist for a copy.

Mian Family Medicine, LLC

Notice of Privacy Practices:

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.

Notice of Privacy Practices Acknowledgement Page:

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org**.**

Pt. Printed Name: ____________________________________ Date: _______________

Pt. Signature: _____________________________ Witness: ________________________

Mian Family Medicine, LLC

Authorization to Release Health Information

Patient Name: ___________________________ Date of Birth _____/_____/_____

Phone number: __________________________ Social Security #: ____-____-_____

Please send Records To: Send From:

Mian Family Medicine ___________________________
9114 Philadelphia Rd, Suite #214 ___________________________
Baltimore, MD 21237 ___________________________
Ph: 443-231-5711 ___________________________
Fax: 443-231-5790 ___________________________

I authorize this information to be faxed and/or mailed.
This information is being disclosed for the purpose of Continuing Health Care.
Records are being requested for healthcare covering the period (s):

All (circle if choice) or From: __________ To: _____________

Complete Health Record to be disposed or (Circle appropriate choices)

History and Physical Exam	Progress Notes
Discharge Summary	X-rays/Ultrasounds
Laboratory Tests	Consultations

I understand that specific information to be released may or may not include AIDS or HIV, Alcohol and/or Drug Abuse and Mental Health.
I understand that if I request copies of records for myself and or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization with expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that the authorization may be revoked in writing at anytime, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.
I understand that there may be a fee for preparing and furnishing this information.

_________________________________ ____/____/_____
Signature of Patient/legal representative Date
Relationship to patient

PLEASE LIMIT FAXED PAGES TO NO MORE THAN 25 SHEETS. Any records which are more than 25 pages maybe mailed to the above address.