INFECTIOUS DISEASE ASSOCIATES, P.A.
PATIENT'S PERSONAL HISTORY

Date: __________ M.D. __________
Chart: _________ Initial: __________

Confidential Record: Information contained here will NOT be released unless you have authorized us to do so.

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1. PATIENT Name: ____
Last First Middle

2. Address: ____
Street Apt# City State ZIP

3. Male/Female 4. Employer (name/address) ____

5. What is the best way to contact you: (Circle One) Home Phone Work Phone Cell Phone

Can messages be left on answering machine: (Write yes/no**)** __________ __________ __________

Email Address: ____

6. Home phone ( ) ________________ 7. Work Phone ( ) ____________________ 8.Cell Phone ( ) _________________
Ext.

9. Age ____ Date of birth ____/____/____ 10. Social Security# (Last 4) __________

11. Marital Status: M S D W Spouse/Partner: ______________ Pharmacy: ______________________________

12. Physician who referred you here: _________________________ Phone # _________________________
13. Primary Care Physician: _________________________ Phone # _________________________

14. Name of Insurance Providers: 1) ____
2) ____
3) ____

15: DO YOU HAVE YOUR INSURANCE CARDS WITH YOU? YES NO
IF YES, please give cards to the receptionist for copying, if NO, please inform the receptionist.

16. Emergency Contact Person:
Name: ________________________________ Phone #: _____________________

Relationship to you: ____

I have completed this form and certify that I am the patient or the authorized general agent of the patient authorized to furnish the information requested. I understand and agree that I am responsible for any co-pays, deductibles, co-insurance, and for payment of services not paid an/or not covered by the insurance policy. I understand that I am responsible for ensuring that my insurance company pays within 60 days from the date of submission of acceptable claims, and for maintaining a routine check on all insurance payments and denials.

Date: ____________________ Signature of Patient: ____________________________________

If YOU are signing for the patient please PRINT YOUR NAME and YOUR RELATIONSHIP to the patient:

Name: ______________________________________ Relationship: ___________________

I authorize Infectious Disease Associates, P.A. to apply for benefits on my behalf for services rendered by B. Mark Landrum, M.D., Robert W. Ross, M.D., Prashanth P. Santhekadur, M.D., Angela M. Kopack, M.D., Sara Taherkhani, M.D., and Mihaela Carter, M.D. I request payment from my insurance company be made directly to Infectious Disease Associates, P.A. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. 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. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

____
Signature of subscriber or beneficiary DATE

FAMILY HISTORY: IF LIVING IF DECEASED
Age Medical problems Age at Death Cause

INFECTIOUS DISEASE ASSOCIATES, P.A.

PATIENT'S PERSONAL HISTORY

Father____

Mother____

Brothers/Sisters ______________________________

Children _____________________________________

____

Personal History

Do you smoke? Yes No How many packs a day? ____________ How many years? ________

Do you drink alcohol Yes No How many drinks per day? ___________ How many per week? ______

Past surgeries:

Date (month/year)	Surgery	Reason

MEDICAL PROBLEMS, ILLNESSES, INJURIES, OR ACCIDENTS ______________________________

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____

Have you ever had an allergic reaction to a medication? Yes No

Medication: ______________________ Reaction______________________

______________________ ______________________

______________________ ______________________

CURRENT MEDICATIONS	DOSE OF MEDICATION

EXPOSURES: Have you been exposed to. . . ?

TB	Yes	No
Travel outside of USA	Yes	No
Blood transfusions	Yes	No
Tick bites	Yes	No
Mosquito bites	Yes	No
Do you have pets or birds?	Yes	No
Type of pets ______________		
Outdoor activities (camping, fishing, hiking, gardening)	Yes	No

____

GENERAL: Do you have. . . ?

Fatigue	Yes	No
Weakness	Yes	No
Chills	Yes	No
Fever	Yes	No
Night sweats	Yes	No
Unintentional Weight loss	Yes	No

If so, how much have you lost? __________

HEAD, EYE, EAR, NOSE, THROAT: Do you have?

Frequent headaches	YES	NO	
Difficulty swallowing	YES	NO	
Ear aches		YES	NO
Sore throat	YES	NO	
Visual changes	YES	NO	
Dental work	YES	NO	

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RESPIRATORY: Do you have?

Shortness of breath	YES	NO
Chronic cough	YES	NO
Productive cough	YES	NO
Wheezing	YES	NO
Blood in your sputum	YES	NO

Lung disease (COPD, Asthma, Emphysema) __________

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NEUROLOGICAL

Spells of weakness of an arm or leg	YES	NO
Unsteady gait	YES	NO
Seizures or convulsions	YES	NO
Numbness	YES	NO
Facial droop	YES	NO

CARDIAC

Chest pain	YES	NO
History of heart murmur	YES	NO
History of rheumatic fever	YES	NO

GASTROINTESTINAL

Nausea	YES	NO
Vomiting	YES	NO
Diarrhea	YES	NO
Heartburn	YES	NO
Loss of appetite	YES	NO
Ulcers	YES	NO
Change in bowel habits	YES	NO
Blood in stools	YES	NO
Black tarry stools	YES	NO
Hepatitis	YES	NO

GENITOURINARY

Burning when urinating	YES	NO
Blood in urine	YES	NO
Dark colored urine	YES	NO
Kidney stones	YES	NO
Prostate problems	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint swelling	YES	NO
Arthritis	YES	NO
Gout	YES	NO
Phlebitis or inflamed leg veins	YES	NO

HEMATOLOGICAL

Anemia	YES	NO
Easy bruising	YES	NO
Easy bleeding	YES	NO
History of blood clots in your legs	YES	NO
History of blood clots in your lungs	YES	NO
Have you ever had a blood transfusion	YES	NO

ENDOCRINE

Diabetes	YES	NO
How long?	YES	NO
Do you have a thyroid disorder	YES	NO
Do you take steroids	YES	NO

SKIN

Psoriasis	YES	NO
Rashes	YES	NO
Skin changes	YES	NO
Unusual moles	YES	NO
Lumps or masses	YES	NO
Ulcers or skin lesions	YES	NO

HAVE YOU HAD

Genital or vaginal discharge	YES	NO
Ulcerations	YES	NO
Itching	YES	NO
Sexually transmitted diseases	YES	NO
HIV infection	YES	NO

PSYCHOLOGICAL

Depression	YES	NO
Anxiety	YES	NO
Difficulty sleeping	YES	NO
Do you snore	YES	NO
Nerve problems	YES	NO

DO YOU HAVE

High blood pressure	YES	NO
Cramps in your legs when walking	YES	NO
Poor circulation	YES	NO

INFECTIOUS DISEASE ASSOCIATES, P.A. - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes the privacy practices of Infectious Disease Associates, P.A. and its personnel at all its locations/offices ("we or "us") with respect to the health information we maintain on our patients ("you").

YOUR HEALTH INFORMATION RIGHTS:

You have the following rights with respect to your health information. Upon request, you may obtain a copy of this notice of privacy practices, inspect your medical records, and obtain, in a reasonable time and for a reasonable copying fee, a copy of your medical record (in paper form, or in electronic form for electronic records). You have the right to request the amendment of inaccurate or incomplete medical records. You may also request reasonable restrictions on uses and disclosures of your medical records, including a restriction of disclosures of your health information to a health plan regarding health care for which you have paid out of pocket in full. You may revoke all or part of an authorization to use or disclose health information (except to the extent that action has already been taken). You may also request an accounting of disclosures of your health information. If we fundraise, you have the right to opt-out of fundraising communications.

OUR RESPONSIBILITIES:

We must comply with the Health Insurance Portability and Accountability Act of 1996. We are required by law to maintain the privacy of your health information and to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must also notify you if there is a breach of your unsecured protected health information. We will not sell your health information, disclose your psychotherapy notes (if any), use your health information for marketing purposes, or disclose your information in a manner inconsistent with this notice without your express written authorization. We must respect your request to limit our use of your health information, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. If we cannot agree to a restriction or request, we must notify you. We reserve the right to change our practices and to make the new provisions effective for all health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice.

THIS NOTICE:

We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all health information we maintain. Should our information practices change, we will promptly post and distribute the new notice either on our website, in our offices, or by mail to our patients.

TO REPORT A PROBLEM:

If you believe your privacy rights have been violated, please contact our HIPAA privacy officer at (410) 418-8550 or idmaryland@gmail.com for further information about the complaint process. You may also file a written complaint with the Secretary of Health and Human Services at www.hhs.gov/ocr. There will be no retaliation for filing a complaint.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

INFECTIOUS DISEASE ASSOCIATES, P.A.
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The following categories describe different ways that we use and disclose your health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples.

Treatment

We will use your health information for treatment. For example, information obtained by a health care practitioner during an examination will be recorded in your record and used to assess a course of treatment. This information may be shared among the members of your health care team so they can implement the course of treatment. We may also provide your primary care physician with information to assist them in treating you. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment

We may use your health information for payment. For example, a bill may be sent to you or a third party responsible for payment. The information on or accompanying the bill may include information that identifies you and information about your care such as diagnosis, procedures, and supplies used.

Health Care Operations

We will use your health information for regular health operations. For example, members of the medical staff may use and share information in your medical record with other health care practitioners to assess the care and outcomes in your case as part of an effort to improve the quality and effectiveness of our care.

Services Provided to Us

There may be some services provided to our organization through contracts with outside vendors that require disclosure of your medical record. For example, we may disclose a medical record to a copy service we use when making copies of your medical record. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with Persons Involved in Your Care

Health professionals, using their best judgment, may discuss your care with a family member, other relative, close personal friends, or any other person you have involved in your care. For instance, we may use or disclose information to help a family member assist you with a treatment regimen we prescribed.

Coroners, Health Examiners, Organ Procurement Organizations, and Funeral Directors

We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties. Additionally, consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Worker's Compensation

We must disclose health information to the extent authorized by and to the extent necessary to comply with Maryland law relating to workers compensation or other similar programs established by law.

Litigation

We may be required to disclose your health information to defend ourselves in civil suits or in response to a third party subpoena authorized by a court or government agency. For instance, if you are receiving treatment for injuries sustained in an automobile accident, we may disclose those records following a subpoena by a party to a civil suit concerning that accident.

Public Health & Health Oversight

As required by law, we may disclose your health information to public health or legal authorities charged with oversight of public health or health care providers. For instance, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, drugs, or medical devices to assist product recalls, repairs or replacement. Your medical records may also be released to an appropriate health oversight agency, such as the Maryland Board of Physicians, with authority over our practice.

Law Enforcement & Corrections:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. For instance, we may be required to disclose evidence of crimes committed at our offices. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGMENT:

PATIENT NAME: ________________________ DATE OF BIRTH: ______________

I acknowledge that I have received this practice's Notice of Privacy Practice written in plain language. The Notice provides in detail uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices as described above, both as to existing information and information to be generated. I understand and have obtained this practice's current Notice of Privacy Practices.

Relationship to Patient (if signed by a personal representative of patient): ______________________________

Patient Name: ____________________________

Signature: ____________________________ Date: ______________________

EFFECTIVE DATE OF NOTICE: July 20, 2014.