ERICKSON HEALTH MEDICAL GROUP

Name: ____________________

Date of birth: ____/____/____

DEMOGRAPHICS

Patient Name: ____
LAST NAME FIRST NAME MIDDLE INITIAL

Home address: ____

Apartment: ____________________ Home Phone: ____________________

Email Address: ____________________ Cell Phone: ____________________

Date of Birth: ____/____/____ SSN#: ____/____/____ Race/Ethnicity: ____________
(OPTIONAL: DO NOT HAVE TO PROVIDE)

Preferred Language: ____________________ Sex: ________ Marital Status: ____________

Preferred Method of Contact: *CHOOSE ONE* ☐ Home phone ☐ Cell ☐ Email ☐ Letter

INSURANCE INFORMATION

Health Insurance: ____________________ Medicare #: ____________________

Address: ________________________________ Effective Date: ____/____/____

Secondary Insurance: ____

Policy #: ____________________ Group #: ____________________

All professional services rendered will be billed to your primary and secondary insurance plans. Copies of your insurance cards will be required to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage and will be billed as allowed by insurance carriers.

Insurance Authorization Assignment:

Name of Policy Holder: ____________________ ID#: ____________________

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to ________________ for any services furnished me by that party who accepts assignment/physician; regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature: ________________________________ Date: ____________________

Please bring your insurance cards so they may be scanned into your chart.

Welcome to our medical practice!

Name: ______________________________

Date of birth: _____/_____/_____

MEDICAL RECORDS REQUEST

I, ______________________________ DOB ______________,

Hereby authorize ______________________________
(NAME OF HOSPITAL, PHYSICIAN, OR MEDICAL FACILITY)

Address: ______________________________

Phone: ______________________________ Fax: ______________

To release my medical records to:
Erickson Health Medical Group of Maryland, Charlestown Medical Center
711 Maiden Choice Lane, Catonsville, MD 21228
Phone: **410-247-5602** Fax: **410-242-1756**

I understand that I have the right to inspect and receive notice of the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization. I understand that I may specify a date for the expiration of this authorization, but it shall be Law, without my expressed revocation, expire one year from the date of signature above.

To Hospital, Medical Facility, or Physician releasing these records:
Please send records that will help us in the future care of the above named patient.

- ☐ Last physical/progress note
- ☐ Last mammogram
- ☐ Colonoscopy
- ☐ Bone density
- ☐ Immunization record
- ☐ EKG
- ☐ Mental health visit notes
- ☐ Drug/alcohol treatment
- ☐ HIV status, if known
- ☐ Radiology
- ☐ One year of lab tests
- ☐ Chest x-ray
- ☐ Other ______________

Please send to our Secure Medical Records Fax: 410-242-1756
Please contact our office if you have any questions regarding this request.

Signature of patient or legal guardian: ______________________________

Date: ______________________________

If other than patient, please state the basis for authority to give consent on patient's behalf:

- ☐ Medical Power of Attorney, Guardianship, Court Order (attach a copy)
- ☐ Relative or Person authorized by law (explain relationship or legal authority)

Specific understandings: By signing this authorization form, you authorize the use of disclosure of your protected health information (PHI) as described above. This information may be disclosed if the recipient(s) described in this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

ERICKSON HEALTH
MEDICAL GROUP

Name: ______________________

Date of birth: _____/_____/_____

CONSENT TO OBTAIN MEDICATION HISTORY

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression.
This information will become part of your medical record.

Signature: ______________________________ Date: ______________________

ERICKSON HEALTH MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

MEDICARE CHRONIC CARE MANAGEMENT SERVICE CONSENT

As part of an ongoing effort to enhance care coordination for Medicare beneficiaries, Erickson Health Medical Group is pleased to offer a new chronic care management service which will help us better coordinate your care. Chronic care management consists of non-face-to-face care services which our office will furnish to assist in coordination of your care among your different care providers and to help you better manage your care. This service would be a complement to face-to-face services you receive, such as office visits.

As part of this service the Medical Center will work with a team of health care providers at our practice to provide care management for your chronic conditions, such as to:

- Create a comprehensive care plan, which will be made available to you either in a written or electronic format and may be periodically revised.
- Coordinate and communicate with other health professionals outside of our practice who are also involved in your care. (Please note, this communication will be done in accordance with all state and federal privacy and security laws.)
- Help you manage care transitions between and among health care providers and settings, including referrals to other clinicians, follow up after an emergency department visit, and follow up after discharges from hospitals or other care facilities.
- Have Charlestown Medical Center team, accessible 24 hours a day, 7 days a week to help you with any urgent chronic care needs and to coordinate with other health care providers involved in your care.
- Review and track your key health information such as problems, laboratory results, medications and medication allergies as well as help you know when to receive recommended preventative screenings.

By signing this consent form, you agree to allow Erickson Heath Medical Group to bill Medicare for chronic care management services on your behalf no more frequently than once per month. This service may be billed even if you do not come into the office that month. Your insurance will not be billed during months in which less than 20 minutes of non-face-to-face chronic care management is provided.

I permit Erickson Health Medical Group to bill Medicare for chronic care management services provided to me.

Signature: ______________________________ Date: ______________________

ERICKSON HEALTH MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

CONTACTS

EMERGENCY CONTACT INFORMATION (List in order you want them contacted)

1.) Name: ______________________ Relationship: __________

Phone #: ______________________ Cell #: ______________________

Email Address: ______________________

Address: ______________________

I authorize this person to have access to my medical information: ☐ YES ☐ NO

2.) Name: ______________________ Relationship: __________

Phone #: ______________________ Cell #: ______________________

Email Address: ______________________

Address: ______________________

I authorize this person to have access to my medical information: ☐ YES ☐ NO

3.) Name: ______________________ Relationship: __________

Phone #: ______________________ Cell #: ______________________

Email Address: ______________________

Address: ______________________

I authorize this person to have access to my medical information: ☐ YES ☐ NO

PHARMACY INFORMATION

Please list the outside pharmacies that you currently use.

Pharmacy Name	Address	Telephone/Fax #s

ERICKSON HEALTH
MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

PREVIOUS AND CURRENT DOCTORS

Previous/Current Primary Care Physician

1. Name: ______________________ Specialty: ______________________
   Address: ______________________
   Telephone: ______________________ When last seen: ______________________

Specialist

1. Name: ______________________ Specialty: ______________________
   Address: ______________________
   Telephone: ______________________ When last seen: ______________________

2. Name: ______________________ Specialty: ______________________
   Address: ______________________
   Telephone: ______________________ When last seen: ______________________

3. Name: ______________________ Specialty: ______________________
   Address: ______________________
   Telephone: ______________________ When last seen: ______________________

4. Name: ______________________ Specialty: ______________________
   Address: ______________________
   Telephone: ______________________ When last seen: ______________________

5. Name: ______________________ Specialty: ______________________
   Address: ______________________
   Telephone: ______________________ When last seen: ______________________

ERICKSON HEALTH MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

CURRENT MEDICATIONS

Medication Name	Dosage (strength)	Frequency (times/day)

Are your medications managed by: ☐ self ☐ agency ☐ family ☐ pharmacy ☐ other ______________

I understand why I am taking the above medications. ☐ Yes ☐ No

Are there barriers that prevent you from safely taking the prescribed medication(s) (poor vision, swallowing difficulties, size of pill, number of medications, frequency or cost)?

____

____

Erickson SENIOR LIVING™ | ERICKSON HEALTH MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

MEDICAL HISTORY

Check any medical problem you have experienced in your lifetime.

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Coronary Disease
- ☐ Heart Attack or MI
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Heart Arrhythmia
- ☐ Heart Valve Problem
- ☐ Stroke
- ☐ TIA
- ☐ Parkinson's Disease
- ☐ Dementia
- ☐ Neuropathy
- ☐ Reflux or GERD (Heartburn)
- ☐ Colon Polyps
- ☐ Gallstones
- ☐ Diverticular Disease
- ☐ Ulcers—Stomach, Duodenal
- ☐ Gastrointestinal Bleeding
- ☐ Kidney or Bladder Stones
- ☐ Diabetes
- ☐ Urinary Incontinence
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Skin Cancer
- ☐ Arthritis
- ☐ Chronic Insomnia
- ☐ Sleep Apnea Syndrome
- ☐ Frequent Falls
- ☐ Asthma
- ☐ Macular Degeneration
- ☐ COPD or Emphysema
- ☐ Anemia
- ☐ Blood Clots, DVT
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Hypothyroidism
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Psychiatric Treatment
- ☐ Problems With Alcohol
- ☐ Other ______________________

____

____

____

____

____

____

ALLERGIES

Drug/Allergen	Reaction/Symptoms

ERICKSON HEALTH MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

HOSPITALIZATIONS/SURGERIES

Date	Medical Conditions/Hospitalization/Surgery

FAMILY HISTORY

	FATHER Birth year: ______ Deceased: ______	MOTHER Birth year: ______ Deceased: ______	SIBLING Brother or Sister? Birth year: ______ Deceased: ______	SIBLING Brother or Sister? Birth year: ______ Deceased: ______	SIBLING Brother or Sister? Birth year: ______ Deceased: ______	CHILD Son or Daughter? Birth year: ______ Deceased: ______
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
COPD						
Mental Health						
Other						

ERICKSON HEALTH
MEDICAL GROUP

Name: ____________________

Date of birth: ____/____/____

SOCIAL HISTORY

Do you have children? ☐ Yes (How many?__________) ☐ No

Your occupation: ____________________ Year retired: ____________

Highest level of education: ____________________ Marital status: ____________

Tell us about your interests and hobbies (do you like to swim, work out, play games/ cards, spend time with family/friends?):

____

____

____

Do you drive an automobile? ☐ Yes ☐ No

Is there a firearm in your home? ☐ Yes ☐ No

If yes, is it kept loaded? ☐ Yes ☐ No

Is it kept locked? ☐ Yes ☐ No

ADVANCED DIRECTIVES

Do you have a Medical Power of Attorney? ☐ Yes ☐ No

If yes, have you turned paperwork into the office? ☐ Yes ☐ No

Do you have a Directive to Physician? ☐ Yes ☐ No

If yes, have you turned paperwork into the office? ☐ Yes ☐ No

Do you have a Do Not Resuscitate Order (DNR)? ☐ Yes ☐ No

If yes, have you turned paperwork into the office? ☐ Yes ☐ No

Erickson SENIOR LIVING™ | ERICKSON HEALTH MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

REVIEW OF SYSTEMS

Please indicate below if you have experienced any of these symptoms in the past 3 months.

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weakness
- ☐ Weight gain or loss

EYES
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Double vision
- ☐ Irritation
- ☐ Discharge
- ☐ Pain
- ☐ Light sensitivity
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Dry eye

EAR/NOSE/THROAT
- ☐ Earache
- ☐ Ear discharge
- ☐ Ringing in ear
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Post-nasal drip
- ☐ Dry mouth

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Syncope/fainting
- ☐ Shortness of breath on exertion
- ☐ Peripheral edema
- ☐ Palpitations
- ☐ Chest tightness
- ☐ High blood pressure

RESPIRATORY
- ☐ Cough
- ☐ Wheezing
- ☐ Excessive sputum
- ☐ Coughing up blood
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Abdominal pain
- ☐ Dark or bloody stool
- ☐ Jaundice
- ☐ Indigestion/ heartburn
- ☐ Irritable bowel syndrome
- ☐ Loss of appetite
- ☐ Bloating
- ☐ GERD

GENITOURINARY
- ☐ Incontinence/ loss of control
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Abnormal vaginal bleeding
- ☐ Pelvic pain
- ☐ Change in urinary pattern
- ☐ Urination during the night
- ☐ Using a pad or brief
- ☐ Erectile dysfunction

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Falls
- ☐ Neck pain
- ☐ Spinal stenosis
- ☐ Use of assistive device

DERMATOLOGICAL
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious lesions
- ☐ Change in moles
- ☐ Bruising
- ☐ Abnormal growth
- ☐ Melanoma
- ☐ Skin ulcer

NEUROLOGICAL
- ☐ Numbness
- ☐ Seizures
- ☐ Syncope/fainting
- ☐ Tremors
- ☐ Headaches
- ☐ Vertigo/dizziness
- ☐ Unsteady gait
- ☐ Restless legs
- ☐ Peripheral neuropathy

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Hallucinations
- ☐ Suicidal ideation
- ☐ Loses train of thought
- ☐ Paranoia
- ☐ Grief
- ☐ Confusion
- ☐ Trouble sleeping

ENDOCRINOLOGY
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Frequent urination
- ☐ Weight change
- ☐ Hot intolerance
- ☐ Cold intolerance
- ☐ Stretch marks

HEMATOLOGY
- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Enlarged lymph nodes
- ☐ Anemia

ALLERGY
- ☐ Urticaria/hives
- ☐ Hay fever
- ☐ Infections

ERICKSON HEALTH
MEDICAL GROUP

Name: ______________________

Date of birth: ____/____/____

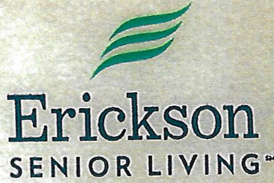
TESTS/SCREENINGS AND PREVENTION

Test/Screening	Yes	No	Details
Pneumovax (Pneumonia) Vaccine	☐ Yes	☐ No	Date Received: ______________
Prevnar 13 Vaccine	☐ Yes	☐ No	Date Received: ______________
Shingrix Vaccine	☐ Yes	☐ No	Date Received 1st dose: __________ Date Received 2nd dose: __________
Zostavax (Shingles) Vaccine	☐ Yes	☐ No	Date Received: ______________
Influenza Vaccine	☐ Yes	☐ No	Date Received: ______________
Tetanus Vaccine	☐ Yes	☐ No	Date Received: ______________
Mammogram	☐ Yes	☐ No	Date Performed: ______________ Location: ______________
Colonoscopy	☐ Yes	☐ No	Date Performed: ______________ Location: ______________
Bone Density	☐ Yes	☐ No	Date Performed: ______________ Location: ______________
Eye Exam	☐ Yes	☐ No	Date Performed: ______________ Location: ______________
Annual Wellness Visit	☐ Yes	☐ No	Date Performed: ______________ Location: ______________
COVID Vaccine	☐ Yes	☐ No	Date Received 1st dose: __________ Date Received 2nd dose: __________

Are there any other concerns you'd like to discuss with your doctor at today's visit?

____

____



Name: ______________________

Date of birth: _____/_____/

Annual Wellness Visit: Health Assessment

We strive to provide the best and most comprehensive care to you; care that helps you be well and stay well. The annual wellness visit is an opportunity to focus on your personal health and wellbeing from a holistic perspective. To achieve this, it is important to update your provider with the most current health information. In addition, during your upcoming visit, you and your provider will develop a personalized plan that will assist you in reaching your goals. These goals may be anything from "simply feeling better" to "eating better to manage my diabetes" to "attending my grandson's graduation next year" or even "getting back to golf". Please begin with these two questions so that we can understand what you hope to achieve in the year ahead.

What are your personal goals for the coming year?

____

____

____

What is preventing you from realizing these goals?

____

____

____

Please bring this filled out packet one week prior to your appointment.

Thank you for completing these forms so that we can better serve you.

V7 3/16/2022

Erickson SENIOR LIVING℠ | ERICKSON HEALTH MEDICAL GROUP

Name: ______________________________

Date of birth: _____/_____/

HEALTH ASSESSMENT

1. Compared to other people your age, would you say that your health is:

☐ Excellent ☐ Very good ☐Good ☐ Fair ☐ Poor

2. Are you taking all of your medications as prescribed?

☐ Yes ☐ No

3. How would you rate your sleep quality overall during the past month?

☐ Very good ☐ Fairly good ☐ Fairly bad ☐ Bad

4. Do you follow any special diet?

☐ Yes ☐ No

5. Are you physically active or do you exercise regularly?

☐ Yes ☐ No

6. Do you engage in activities to maintain your mental health and wellbeing?

☐ Yes ☐ No

7. In the past year, have you felt you had more problems with your memory or have you had friends or family members share concerns about your memory?

☐ Yes ☐ No

8. Are you experiencing stress?

☐ Yes ☐ No If yes, rate your personal level of stress in your life:

☐ Slight ☐ Average ☐ Above average ☐ Significant

9. Please describe your current vision:

☐ Excellent ☐ Good ☐ Fair ☐ Unable to see at all

☐ Use eyeglasses/magnifying glass/contact lenses

10. Please describe your current hearing:

☐ Excellent ☐ Good ☐ Fair ☐ Unable to hear at all ☐ Use hearing aid/device

11. Do you experience pain on a regular basis?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Erickson SENIOR LIVING™ | ERICKSON HEALTH MEDICAL GROUP

Name: ____________________

Date of birth: ____/____/____

12. Do you need help with any of the following?

	Yes	No
Shopping for personal items like groceries, toiletries or medicine	☐	☐
Managing money (keeping track of expenses/paying bills)	☐	☐
Doing housework or laundry	☐	☐
Getting to places outside of walking distance	☐	☐
Using the toilet	☐	☐
Bathing or showering	☐	☐
Dressing yourself	☐	☐
Preparing meals and feeding yourself	☐	☐
Using the telephone	☐	☐

Falls Risk Assessment

13. Do you feel unsteady or have a fear of falling?

☐ Yes ☐ No

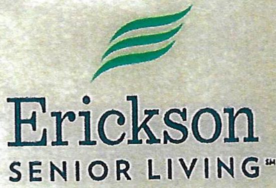
14. Have you had a fall in the past year?

☐ Yes ☐ No

If yes, how often have you fallen in the past year?

☐ One fall, no injury ☐ One fall, with injury ☐ Two or more falls, no injury

☐ Two or more falls, with injury



ERICKSON HEALTH MEDICAL GROUP

Name: ____________________

Date of birth: ____/____/

Alcohol Screen

15. Do you sometimes drink beer, wine, or other alcoholic beverages?

☐ Yes ☐ No

If yes, have you had one or more days in the past year where you drank more than four drinks in one day? ☐ Yes ☐ No

Tobacco Screen

16. Do you or anyone in your household smoke cigarettes, electronic cigarettes, cigars, pipes, or do you use smokeless products such as dip or chewing tobacco?

☐ Yes Regularly (daily or weekly) ☐ Yes Occasionally (less than weekly) ☐ No

Depression Screen

17. In the past two weeks, how often have you been bothered by any of the following:

Little interest of pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Advanced Directive

18. Do you have an Advance Directive, living will, or power of attorney that contains your wishes for end of life care

☐ Yes ☐ No