PATIENT INFORMATION SHEET – Please Print – Complete All Information

SOCIAL SECURITY # ___________ - ________ - ___________ TODAY'S DATE: ______________________

LAST NAME: ______________________________ SUFFIX: ________ FIRST NAME: _________________________ MI: ______

ADDRRESS: ____ CITY: ______________________ STATE: _____ ZIP:________

HOME PHONE: (______) _________________________ WORK PHONE: (______) _______________________ EXT: __________

DATE OF BIRTH: ______________ MARRIED: ______ SINGLE: ____ WIDOWED: ___ DIVORCED: ___ SEX: ___MALE ____ FEMALE

DRIVER'S LICENSE #: ______________________________ EMERGENCY CONTACT: _______________ PHONE: (____) ________

CELL PHONE/PAGER: (___) _________ FOR MINORS: MOM'S WORK PHONE: (_____) _________ DAD'S WORK PHONE: (____) ________

PHARMACY: _______________________________ ADDRESS: _______________________________ PHONE: (_____) ________

EMPLOYER: ______________________________________ ADDRESS: ____

PHONE: (___) ______ EMPLOYMENT STATUS: __FULL-TIME __PART-TIME ___UNEMPLOYED ___STUDENT ___HOUSEWIFE/HUSBAND

REFERRED BY: DOCTOR ___________________________________ ADDRESS _______________________________________

FRIEND __________________ OTHER PATIENT _______________ INSURANCE CO. _____________ OTHER _______________

PRIMARY INSURANCE COVERAGE

RESPONSIBLE PARTY FOR BALANCE: ______ SELF _______ PARENT ______ OTHER (explain) _____________________________

PRIMARY INSURANCE: ________________________________ CLAIMS ADDRESS: ____

CITY: ____ STATE: ______ ZIP CODE: ____________ PHONE: (_____) __________

CO-PAY: $____________ SUBSCRIBER (PERSON WHO OWNS THE INSURANCE): ____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ____________________ SUBSCRIBER'S SOCIAL SECURITY #:_______ - _____ - _______

SUBSCRIBER'S ADDRESS: __________________________________ CITY________________ STATE_____ ZIP CODE__________

HOME PHONE: (____)___________ WORK PHNE: (_____) __________ BIRTH DATE: _____________ SEX: _____MALE _____ FEMALE

SUBSCRIBER'S EMPLOYER: ___________________ ADDRESS: _______________ CITY: __________ STATE: ___ ZIP CODE:______

INSURANCE POLICY ID #: ______________________ GROUP #: ___________ EFFECTIVE DATE OF INSURANCE: ___________ _____

SECONDARY INSURANCE COVERAGE

PRIMARY INSURANCE: ________________________________ CLAIMS ADDRESS: ____

CITY: ___________________________________ STATE: ________ ZIP CODE: ______________ PHONE: (_____) ____________

CO-PAY: $_____________ SUBSCRIBER (PERSON WHO OWNS THE INSURANCE): ____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ______________________ SUBSCRIBER'S SOCIAL SECURITY #:_______ - ___ - ________

SUBSCRIBER'S ADDRESS: __________________________________ CITY: __________________ STATE: _____ Z IP CODE: _________

HOME PHONE: (___) __________ WORK PHONE: (___) _____________ BIRTH DATE: _______________ SEX: _____MALE _____ FEMALE

SUBSCRIBER'S EMPLOYER: _________________ ADDRESS: _________________ CITY: ____________ STATE: ____ ZIP CODE:_____

INSURANCE POLICY ID #: ____________________ GROUP #: _________________ EFFECTIVE DATE OF INSURANCE: ______________

Dr. Jeffrey D. Gaber & Associates, PA

PATIENT'S NAME:______________________________ DOB:__________

(Please Print)

CONSIGNMENT & ASSIGNMENT – PLEASE READ BEFORE SIGNING

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

BLUE SHIELD OF MARYLAND

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. or Carefirst, Inc. payment and, if greater, I will be responsible for that amount. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

COLLECTION FEES

The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of twenty-five percent (25%) of the outstanding balance at the time of referral, which percentage and the amount resulting there from are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

INSURANCE ASSIGNMENT

I hereby assign, transfer and set over to Dr. Jeffrey D. Gaber & Associates, P.A. all of my rights, title, and interest to my reimbursement benefits under my insurance policy with ______________________________ Insurance Company.

MANAGED CARE

I understand that, without an authorization/referral from my insurance carrier, if so required, that I will be financially responsible for 100% of charges I and/or the patient incur.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

Below I affix my seal.

Signature: ______________________________ Date: ____________________

I authorize a copy of this authorization to be used in place of the original.

GUARANTEE

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to Dr. Jeffrey D. Gaber & Associates, P.A., and its successors and assigns, the full and complete payment due by the patient, on the same terms and conditions as the patient, as and when the same becomes due.

SIGNATURE OF SPOUSE Below I affix my seal.

Signature: ______________________________ Date: ____________________

Dr. Jeffrey D. Gaber
& Associates, PA

Self-Pay Waiver
For Private Patients

I, ________________________________, understand and agree that I will be held responsible for any and all services that I receive by and through Dr. Jeffrey D. Gaber & Associates, P.A., that are not covered by my health maintenance/insurance plan.

I further understand that I will be held responsible for payment of these services in full, in the event that my health insurance does not cover these charges.

Agreed: ________________________________

Date: ________________________________

Witness: ________________________________

Dr. Jeffrey D. Gaber & Associates, PA

BY SIGNING BELOW I ACKNOWLEDGE RECEIVING DR. JEFFREY D. GABER & ASSOCIATES, PA'S "NOTICE OF PRIVACY PRACTICES."

Patient's Name: ______________________________

Date of Birth: ______________________________

______________________________ Signature of Patient or Legal Guardian

______________ Date

PATIENT AUTHORIZATION FOR PRACTICE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Dr. Jeffrey D. Gaber & Associates, PA to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization is needed for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing except to the extent that Dr. Jeffrey D. Gaber & Associates, PA has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Dr. Jeffrey D. Gaber & Associates, PA. I further understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines.

This authorization permits Dr. Jeffrey D. Gaber & Associates, PA to use or disclose to _________________________ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, patient's name, age, race, condition or other medical or demographic information)

- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Drug or Alcohol Treatment Records
- ☐ Emergency Room Records
- ☐ Medical Records/Notes
- ☐ Mental Health Records
- ☐ Operative Report
- ☐ Outpatient Records
- ☐ Outpatient Surgery
- ☐ Pathology Report
- ☐ X-Ray Report
- ☐ Other ______________________

I understand that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

This authorization expires on (upon) __________________________

Signed By: ________________________________ ____________________

Signature of Patient or Legal Guardian — Relationship to Patient

________________________________ ____________________

Patient's Name — Date

________________________________ ____________________

Print Name of Patient or Legal Guardian — Date of Birth

HISTORY & PHYSICAL

Name ______ SS# ______ Date ______
Address ______ Occupation ______
Phone (home) ______ (work) ______ Date of birth ______ Age ______
Chief complaint ______

DRUG ALLERGIES

CURRENT MEDS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

❑ Headache ______
❑ Shortness of breath ______
❑ Heart palpitations ______
❑ Heart murmur ______
❑ Chest pain ______
❑ Dizziness/Fainting ______
❑ Peripheral vascular disease ______
❑ Allergies/Hay fever ______
❑ Asthma ______
❑ Bronchitis ______
❑ Pneumonia ______
❑ Ulcer ______
❑ GI disorder ______
❑ Lactose intolerance ______
❑ Gallbladder disease ______
❑ Prostate disease ______
❑ Bowel irregularity ______
❑ Incontinence ______
❑ Sexual/menstrual dysfunction ______
❑ Venereal disease ______
❑ Frequent infections ______
❑ Hepatitis ______
❑ Anemia ______
❑ Arthritis ______
❑ Osteoporosis ______
❑ Nervousness ______
❑ Depression ______
❑ Gout ______
❑ Scarlet fever ______
❑ Chronic rashes ______
❑ Rheumatic fever ______
❑ Mumps ______
❑ Measles ______
❑ Rubella ______
❑ Polio ______
❑ Diphtheria ______
❑ Tetanus ______
❑ Other ______
❑ Other ______

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

MEN ONLY: *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* ❑ *Yes* ❑ *No*
How often does this occur? ❑ *Frequently* ❑ *Sometimes* ❑ *Rarely*

HABITS

❑ Smoke: Packs daily ______
How long? ______
Interested in stopping? ______
❑ Exercise routine: ______

❑ Coffee: Cups daily ______
Other caffeine ______
❑ Alcohol: Type ______
Amount ______
❑ Diet: Salt intake ______
Fat intake ______

❑ Sleep: Difficulty falling asleep ______
Continuity disturbances ______
Snoring ______
Early morning awakening ______
Daytime drowsiness ______
Other ______

Name
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