



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

As a patient, you have the right to be informed about the state of your health and any recommended medical, diagnostic or surgical procedure that will be used in the course of your care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If you have been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined.

If you are a new patient with this practice, no specific treatment plan has yet been recommended.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during the course of your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing in order to assess your health and recommend treatment. You authorize this practice, your assigned physician and/or advanced practice clinician (Nurse Practitioner or Physician Assistant), and any employee working under the direction of the physician or other advanced practice clinician, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the prescribing of drugs, devices, equipment or other items required to diagnose and treat a medical condition. This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician or health care provider. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms specific to the test(s) or procedure(s) to be performed.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient Signature (or Guardian if signing for another person)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness Name (please print)



**The Right to Obtain a Copy of this Notice.** You have the right to a paper copy of this notice at any time. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at registration or contact our Privacy Officer at the address or phone number located at the end of this document. You may obtain a copy of this notice at our website, [www.CalvertHealthMedicalGroup.org](http://www.CalvertHealthMedicalGroup.org).

**Your Rights Regarding Your Protected Health Information.** We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice. The notice will always contain on the first page, the effective date of the Privacy Notice.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us and the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to the address provided at the end of this notice. You will not be penalized for filing a complaint.

**Contact Information**

If you require further information about this Notice, have privacy issues or believe that your privacy rights have been violated, please contact:

CalvertHealth Medical Group  
Attn: Privacy Officer  
100 Hospital Road  
Prince Frederick, MD 20678

**Effective Date**

This Notice is effective January 1, 2017.

By signing this document, I acknowledge that I have read and understood this Privacy Notice and that a copy of CalvertHealth Medical Group' Privacy Notice was offered to me.

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Patient Signature

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Date

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Print Name

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DOB



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank you for choosing CalvertHealth Medical Group (CHMG) as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

**Insurance:** Knowing your insurance benefit plan is your responsibility. It is your responsibility to make sure that our providers participate in your insurance company's plan and that the correct in-network facility is used for all test and hospital encounters. Please contact your insurance company with any questions you may have regarding your coverage.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, or if you choose to submit your claim yourself, payment in full is expected at each visit. We will provide you with appropriate documentation so that you can submit a claim to your insurance company.

If we do participate in your plan, but you do not have a **current insurance card** or the **designated primary care provider** is not a CHMG provider, payment is required in full for each visit until we verify coverage. Alternatively, if we do not participate in your insurance plan and you choose to see our providers, or if you do not have insurance and choose to see our providers, you will be considered 'self-pay' subject to the terms defined later in this document.

**Proof of Insurance:** If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government issued photo ID and your current insurance card. This information must be provided prior to seeing a provider (physician, nurse practitioner or physician assistant).

**Claims Submission:** Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit claims we require the patient's name, address and date of birth, as well as the policyholder's name, address and date of birth. This information must match exactly what your insurance company has on file for you, including exact name, address and policy number. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you will become responsible for the full amount of the services provided.

**Coverage Changes:** Please notify us before your scheduled appointment if any of your insurance information has changed. This includes changes of employer, insurance provider, address, policy number, covered dependents, etc. Not having up-to-date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the full amount of the services provided.

**Co-Payments:** If your insurance company requires co-payments, those co-payments must be paid at the time of service. We collect co-pays at the point of appointment check in, not when you check out.

**Deductibles and Out-Of-Pocket Expenses:** We will bill you for any outstanding balance once your insurance company has processed your claim and made payment to us. This balance may include your contracted deductible or other out-of-pocket expense as determined by your insurance policy. Payment for outstanding balances is expected within 30 days of the statement date.

**Referrals:** It is your responsibility to obtain any necessary referrals from your primary care provider prior to receiving treatment. Patients who elect to receive service without a proper referral will be required to sign a waiver and will be expected to pay for the service prior to treatment.

**Payment:** We accept payment by cash, debit card, check, VISA, MasterCard, Discover and American Express. All outstanding balances must be paid at time of service unless prior arrangement has been made with the CHMG billing office. As a convenience to our patients, all CHMG practices are able to collect payments for all other CHMG practices.

**Returned Check Fee:** We charge a \$25.00 fee for returned checks. If a second check is returned, in addition to the returned check fee, you will be asked to pay by cash, money order, cashiers' check or credit card for future visits.



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Self-Pay:** A Self-Pay patient is any patient who: does not have health insurance; chooses to submit their own claims, see a CHMG provider who does not participate in their health insurance plan, receive a service that requires a referral from their insurance company or primary care provider when they do not have the referral with them or receive a treatment they know is not covered by their insurance company. Self-pay patients will be charged a discounted fee for the services provided (please see comments and exceptions regarding physicals in the section below). Additional discounts may apply, and the patient may qualify for special consideration such as sliding scale; please see the receptionist for information regarding any available discount programs.

**Sliding Scale:** If you do not have insurance, you may be eligible for a reduction in fees for healthcare services based on your income. Please ask the receptionist for an application for Sliding Scale or contact our billing office to discuss eligibility requirements.

**Non-Payment:** If your account becomes delinquent, you agree to pay any charges that CHMG incurs to collect your unpaid bills, including but not limited to reasonable court costs and collection agency fees. Your account will be considered delinquent when it is 60 days past due. If your account becomes delinquent, you will receive a letter stating that you have 14 days to bring it current by paying the entire outstanding amount unless you contact us to make other payment arrangements. Other payment arrangements may include establishing a payment plan with us that results in full payment of the outstanding balance being made within six (6) months from the time when the account becomes delinquent.

Please be aware that if a balance remains unpaid, we may refer your account to a collection agency or a collection attorney. You understand and agree that, should your account be forwarded to a collection agency or attorney, you will pay a collection fee of 35% of the balance plus a processing fee of \$25.00 in addition to the outstanding balance being collected. If the filing of a lawsuit is required to collect your outstanding balance, the collection fee will be 50% of the cost to collect the debt in addition to the amount of the outstanding balance plus any other applicable fees.

In the event of non-payment, CalvertHealth Medical Group may use an outside agency to verify yours and/or your spouse's employment and credit history in order to assess your ability to pay and offer you other payment solutions such as sliding scale

**Minor Patients:** Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of the appointment.

**Physicals:** Department of Transportation (DOT), 500, sports, camp and work physicals are not covered by many insurance companies. Payment for these services is expected at the time of service.

**Form Completion:** Your provider (physician, nurse practitioner or physician assistant) is available to complete medical forms or certifications that you may require. If you require a form to be completed during a visit that is not related to the stated purpose for the visit, a separate fee of \$25.00 will be charged. For example, if you come in for a well-child visit and request a sports physical certificate to be completed, completion of the certificate is subject to the \$25.00 fee.

**Missed Appointments/Missed Procedures:** Our policy is to charge patients for missed appointments and procedures that are not cancelled at least 24 hours prior to the scheduled appointment or procedure. Please refer to the No-Show/Late Cancellation Fee Policy that is included in our New Patient Packet and is required to be reviewed and agreed by all patients at least annually for details of the fees that will be charged.

**Personal Injury Claims:** CHMG does not respond to or accept Letters of Protection from attorneys for automobile accident injuries. CHMG does not have contractual agreements with auto insurance companies or Personal Injury Protection companies and therefore cannot submit claims to such companies for reimbursement or take co-pays. Patients who seek treatment for an injury resulting from an automobile accident are considered 'self-pay' and payment is expected at the time of service, subject to any self-pay discounts that may be available. If the patient has health insurance and plans to have their treatment covered by that insurance company, we will submit claims to their health insurance and collect co-pays as required by that company.

**Account Consultation:** Providers (physicians, nurse practitioners, physician assistants) are not trained to discuss financial issues with patients. Only CHMGs billing staff is trained to discuss your account, including charges, fees, payments and payment arrangements. If you have questions about any of the financial issues related to your account, please contact the **billing office at 410-414-4555**.



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Refunds:** Occasionally, an insurance payment results in overpayment on your account. Any overpayment from an insurance claim will be refunded by check to the insurance company as soon as it is identified. Overpayments that are owed to the patient (i.e. from an overpayment of a co-pay) will be refunded to the patient by check provided there is no other outstanding balance on the patient’s account. Over payments to an insurance company will not be refunded to the patient.

**Worker’s Compensation:** It is your responsibility to file a Worker’s Compensation report with your employer and to provide our office with verification that the report has been filed with the Worker’s Compensation carrier and a claim number assigned. In order to file a claim on your behalf with your Worker’s Compensation carrier, we require the following information for each claim submitted on each date of service: state where injury occurred (i.e. Maryland); date of injury; exact location on the body where the injury occurred and that is covered by the claim (i.e. left wrist); name, address and phone number of insurance carrier; insurance carrier’s claim number; claim adjuster name and contact information.

It is your responsibility to obtain proper authorization from your Worker’s Compensation insurance carrier prior to each visit. If we are unable to verify authorization prior to your visit, you will be required to reschedule your appointment until such time as authorization is verified. Any visit related to a Worker’s Compensation claim will be limited to treatment of the body part for which the claim is filed.

We will file insurance claims on your behalf with your Worker’s Compensation insurance carrier for services provided for the treatment of the related injury until such time as we receive confirmation from the carrier that the case is closed. If your Worker’s Compensation claim is denied and you have health insurance, we will collect co-pays and submit claims to your health insurance company. If the claim is denied and you do not have health insurance, the charges will become your responsibility.

**CHMG Billing Contact Information:**

Physical Address  
CHMG Billing Office  
100 Harrow Lane, Suite 101  
Prince Frederick, MD 20678  
Billing Phone Number: 410-414-4555

Mailing Address  
CHMG Billing Department  
P.O. Box 405962  
Atlanta, GA 30384-5692

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand and agree to the terms of this Patient Financial Policy.

Patient Signature: \_\_\_\_\_ Today’s Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank you for choosing CHMG as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment at least 24 hour prior to the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than 24 hours’ notice. Late cancellations will be treated as a ‘no-show’ per CHMG policy.

**The following policies will apply to ‘no-shows’ and late cancellations/reschedules, combined, on a rolling 12 month period.**

**‘No-Shows’ and late cancellations/reschedules for Office Visits:**

- First offense will prompt a warning letter to the patient regarding their no-show or late cancellation/ reschedule occurrence and a notation will be made in the patient’s chart.
- Second offense will prompt a phone call from the practice manager to the patient, a 2<sup>nd</sup> warning letter will be sent to the patient, and the patient will be charged a \$25 ‘no-show’ or late cancellation/reschedule fee. The practice manager will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the \$25 fee ticket and warning letter, and mail all 3 documents to the patient.
- Third offense will prompt the patient to be discharged from the practice.

**‘No-Shows’ or late cancellations/reschedules for Procedure:**

- Patient will automatically be charged a \$50 ‘no-show’ or late cancellation/reschedule fee. The practice manager will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the fee ticket, and mail to the patient.

**Additional Information:**

The No-Show and Late Cancellation/Reschedule Policy is not provider specific but applies across all CHMG practices, such that a no-show or late cancellation/reschedule at one provider will affect the patient’s ability to schedule appointments with another CHMG provider. **For a listing of affected providers and practices, please go to [CalvertHealthMedicalGroup.org](http://CalvertHealthMedicalGroup.org).**

All applicable no-show and late cancellation/reschedule fees must be paid prior to scheduling future appointments with any CHMG provider.

My signature below certifies that I have read, understand and agree to the terms of the No Show and Late Cancellation/Reschedule Policy.

Patient Signature: \_\_\_\_\_ Today’s Date: \_\_\_\_\_



The CalvertHealth Medical Group Patient Portal is a key component of managing your health. The Patient Portal is a secure, online tool that lets you communicate with your healthcare team and manage your health information.

Using the Portal, you can:

- Review lab results;
- Review your medical history;
- Request medication refills;
- Request appointments;
- Request Referrals;
- Pay your CHMG bill;
- Send your provider or practice questions.

**THE PATIENT PORTAL IS THE PRIMARY METHOD CHMG AND YOUR PROVIDER USE TO SHARE IMPORTANT INFORMATION WITH YOU!**

We will send you secure communications through the portal to:

- Remind you of upcoming appointments
- Notify you of new providers
- Notify you of departing providers
- Notify you of changes to office opening and closing times (i.e. for inclement weather)

**We no longer send notifications by regular mail.** All communications will be by portal message, text message or telephone.

Patients who do not sign up for and activate their Patient Portal access will miss out on key communications and not be able to take advantage of this secure, online, 24/7 access to your medical records, medication refills, lab results, and provider communications.

When you check in for your appointment, we will ask for your email address and give you a token that you will use to activate your access. You will have 30 days from the date you receive it to go online to [nextmd.com](http://nextmd.com) to enter the token and activate your access.

**WE ENCOURAGE YOU TO ACTIVATE YOUR PORTAL ACCESS AS SOON AS YOU GET HOME.**

Once you have activated your portal access, you can click on 'My Chart' then 'Request Health Records' to start downloading your medical records into your portal.

**The Patient Portal is a convenient, secure way to communicate with your provider, manage your medications and monitor your health records. Please sign up and activate your portal access today.**



Patients Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

MRN: \_\_\_\_\_

The State of Maryland is requesting CalvertHealth Medical Group inquire about the ethnicity and race for each patient in order to be in compliance with the Patient Centered Medical Home. **Patient is not required to complete this form. If this form is not complete, the staff will input "Not Specified".**

**Question 1. Ethnicity**

**Are you Hispanic or Latino?**

(A patient of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture of origin, regardless of race.)

- Yes       No       Unknown/Not Specifying

**Question 2. Please select the racial category with which you most closely identify by placing an 'X' in the appropriate box.**

RACIAL CATEGORY	DEFINITION OF CATEGORY
<input type="checkbox"/> American Indian or Alaska Native	A patient having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
<input type="checkbox"/> Asian	A patient having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
<input type="checkbox"/> Black or African American	A patient having origins in any of the black racial groups of Africa.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	A patient having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> White	A patient having origins in any of the original peoples of Europe, the Middle East or North Africa.
<input type="checkbox"/> Multi-Racial	A patient having origins of more than one Racial Category identified above.
<input type="checkbox"/> Unknown/Not Specifying	A patient whose race is unknown OR a patient who does not wish to supply race information.

Information obtained from the Office of Management and Budget.





Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Thank you for taking the time to complete this form. Having a thorough medical history is an important step in our being able to provide you good service and help you achieve good health.

Today's Date: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**CURRENT MEDICATIONS** (You may bring your own list to your appointment if you prefer.)

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	Example: 500Mg	Example: 1 pill three times a day

\* Note: this information may be taken directly from the pharmacy label on prescription products.

<b><u>ALLERGIES</u></b>			
<input type="checkbox"/> No known allergies	<input type="checkbox"/> Medication Allergies	<input type="checkbox"/> Environmental/Seasonal Allergies	<input type="checkbox"/> Latex Allergy
List Allergies		Reaction	

**PAST MEDICAL HISTORY** (Check all that apply)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Acid Reflux/GERD           | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> ADHD                       | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma/Cataracts        | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Liver Disease   |
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Chronic Pain       | <input type="checkbox"/> Hearing Loss              | <input type="checkbox"/> Memory Loss     |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Depression         | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Emphysema/COPD     | <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Other (Please list): _____ |   |  |  |

**PAST SURGICAL HISTORY**

Type of Surgery (operation)	Date



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FAMILY HISTORY** (Check all that apply and indicate which family member)

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma _____               | <input type="checkbox"/> Heart Disease _____       |
| <input type="checkbox"/> Cancer (specify) _____     | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Dementia/Alzheimer’s _____ | <input type="checkbox"/> High Cholesterol _____    |
| <input type="checkbox"/> Depression _____           | <input type="checkbox"/> Stroke _____              |
| <input type="checkbox"/> Diabetes _____             | <input type="checkbox"/> Thyroid Disease _____     |
| <input type="checkbox"/> Emphysema/COPD _____       |  |

**SOCIAL HISTORY**

**Tobacco**

Have you ever smoked?     Yes     No                                      If yes, what do you (did you) smoke? \_\_\_\_\_

Are you still smoking?     Yes     No

If no:    How many years ago did you quit? \_\_\_\_\_    If yes:    How many years have you smoked? \_\_\_\_\_

            For how many years did you smoke? \_\_\_\_\_                                      How many packs per day do you smoke? \_\_\_\_\_

            How many packs per day did you smoke? \_\_\_\_\_                                      Have you ever tried to quit? \_\_\_\_\_

**Alcohol**

Do you drink alcohol, including beer, wine or hard liquor?     Yes     No

If yes:     Daily     Almost Daily (4-6 times per week)     1 – 3 times per week     Less than one time per week

Do you drink caffeine?     Yes     No     If yes, how many cups per day? \_\_\_\_\_

**Illicit Drugs**

Do you use any drugs or prescription medications not prescribed to you?     Yes     No

(Including marijuana, cocaine, amphetamines, pain or anxiety medications, etc.)

If yes, please specify type of drug and frequency of use: \_\_\_\_\_

**Health Planning**

Do you have Advanced Directives in place?     Yes     No

If no, would you like your healthcare Provider to discuss one with you?     Yes     No

If yes, would you like us to include it in your electronic health record?     Yes     No



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HEALTH MAINTENANCE**

**All Patients:**

Last Tetanus Booster	<input type="checkbox"/> Within past 10 years	<input type="checkbox"/> More than 10 years ago	<input type="checkbox"/> Unknown
Last Eye Examination	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Last Hearing Test	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Last sigmoidoscopy/colonoscopy or stool test	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Last DEXA Bone Scan	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Last pneumonia vaccine	Date: _____		
Flu shot this season?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	

**Women:**

Last Pap Smear	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Mammogram	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Perform regular breast exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Last Menstrual Period	Date: _____			
Menopausal	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, at what age? _____		

**Men:**

Last Prostate Specific Antigen – PSA	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Prostate Exam	Date: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Perform regular testicular exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONCERNS:** Please indicate any concerns regarding your health in the space provided: