Dr. Mary Steiner
3016 O'Donnell Street, Baltimore, MD 21224

Date:_____

Last Name:_____ First Name:_____

Birth Date:_____/_____/_____ Gender: Male____ Female____

Status: Married____ Single____ Children_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone: Home:_____Work:_____

Cell:_____Other:_____

Email:_____

Occupation:_____

Employer:_____

Emergency Contact:_____ Phone:_____
Relationship:_____

Referred By:_____

Insurance Carrier:_____

Policy ID:_____ Group #:_____

Primary Account Holder:_____Birthdate: ___/___/__
Relationship to Holder: Self____ Spouse____ Child____

Office Policy

Within this office, your health information is kept confidential at all times. Your information is used solely for treatment, to obtain payment, and for health care operations including administrative purposes and evaluation of the care that you receive.

Payment is expected at the time of service unless prior arrangements have been made. Please be advised that if you choose to use health insurance, benefits are not a guarantee of service or payment. YOU will be responsible for any balance unpaid by your insurance carrier.

Please sign below to acknowledge your understanding of this information.

Signature:_____ Date:____/____/____

Dr. Mary Steiner
3016 O'Donnell Street, Baltimore, MD 21224

Reason for visit:_____

_____

_____

When did pain begin?_____

How did pain begin?_____

Describe the symptoms: (Circle all that apply)

*Sharp pain *Dull pain *Stabbing pain *Numbness *Tingling *Ache

*Other (describe):_____

Describe the frequency/duration of symptoms: (Circle all that apply)

*All night *Morning *Afternoon *Evening *Daily *Weekly *Monthly

*Other (describe):_____

Review of systems: Please circle <u>any</u> symptoms that apply to <u>you</u>.

Cardiovascular: Heart palpitations * High blood pressure * Chest pain * Calf pain * Other:_____

Respiratory: Trouble breathing * Asthma * Shortness of breath * Smoking History: (length of time)_____

Gastrointestinal: Digestive problems * Ulcers * Reflux (GIRD) * Nausea * Other:_____

Genitourinary: Painful urination * Changes in urination color/frequency * Painful coitus * Other:_____

Neurological: Trouble concentrating * Numbness * Headaches * Tremors * Other:_____

Psychiatric: Depression * Hallucinations * Schizophrenia * Memory loss * Other:_____

Endocrine: Menstrual problems * Night sweats * Diabetes * Thyroid dysfunction * Other:_____

Hematological: Bruising easily * MRSA * Anemias * Swelling in legs * Other:_____

Allergic/Immunological: Seasonal allergies * Frequent infections * Other:_____

Eyes/Ears/Nose/Throat: Vision trouble * Hearing dysfunction * Colds/flu * Swallowing difficulty * Other:____

Operations (list date and type):_____

Review of family history: Using the "review of systems above" as a guide, please note any pertinent family history below:_____

_____

Social History: Please circle and describe all that apply to you:

Exercise: Frequency ____ per week/month * Weight training * Cardio * Sports:_____

Activities of Daily Living: Please describe all that are currently being affected by your condition:

Sleeping:_____

Exercising:_____

Job/Work:_____

Driving:_____

Family life:_____

Hygiene (bathing, dressing, teeth):_____

Signature:_____ **Date: _____/_____/_____**