

**Drs. Hauck, Bianchi, Asher & Driscoll**

2415 Musgrove Road, Suite 203  
Silver Spring, Maryland 20904  
(301) 989-2300

**\*\*\*PLEASE PRINT\*\*\***

**ADULT PATIENT'S NAME:** \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

SEX: M F DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ STATE ISSUED: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE \_\_\_\_\_

ALLERGIES TO ANY MEDICATIONS? YES NO NAME OF MEDICATION: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

SPOUSE'S (OR NEAREST RELATIVE'S) NAME : \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ FAMILY DOCTOR: \_\_\_\_\_

**\*\*\*INSURANCE INFORMATION\*\*\***

**PRIMARY** INSURANCE COMPANY NAME: \_\_\_\_\_

ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF INSURED GROUP: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

**SECONDARY** INSURANCE COMPANY NAME: \_\_\_\_\_

ID NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF INSURED GROUP: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

IS **ANY** OTHER INSURANCE IN EFFECT? YES NO IS THIS A LEGAL CASE? YES NO

IS THIS A WORKER'S COMPENSATION CASE? YES NO DATE OF ACCIDENT/INJURY: \_\_\_\_\_

**\*\*\*AUTHORIZATIONS\*\*\***

I, \_\_\_\_\_, hereby authorize Drs. Hauck & Bianchi, P.A. to apply for benefits on my behalf for services rendered to me and request that payment be made by my insurance company and that payments be sent directly to Drs. Hauck & Bianchi, P.A.. I understand that it is the policy of Drs. Hauck & Bianchi, P.A. to only bill my insurance company if they participate in that company, and if they do not, it will be my responsibility to bill my insurance company for reimbursement of my expenses.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection, I agree to pay any collection and reasonable legal fees (*25% is deemed reasonable*) court costs, and other expenses incurred as a result of said collection, all actions having a venue of Montgomery County, MD, other venues not withstanding. Further, I understand that there is a \$25.00 fee for returned checks.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

\_\_\_\_\_  
SIGNATURE DATE

**FOR OFFICE USE ONLY**

UPDATE DATE: \_\_\_\_\_ INITIALS: \_\_\_\_\_ CHANGES? YES NO

UPDATE DATE: \_\_\_\_\_ INITIALS : \_\_\_\_\_ CHANGES? YES NO

UPDATE DATE: \_\_\_\_\_ INITIALS : \_\_\_\_\_ CHANGES? YES NO

UPDATE DATE: \_\_\_\_\_ INITIALS : \_\_\_\_\_ CHANGES? YES NO

UPDATE DATE: \_\_\_\_\_ INITIALS : \_\_\_\_\_ CHANGES? YES NO

**NEW/UPDATED MEDICAL HISTORY  
ADULT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Country of Birth \_\_\_\_\_  
Occupation: \_\_\_\_\_ Date Form Completed \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_

**BRIEFLY, DESCRIBE THE PROBLEM THAT BROUGHT YOU IN TODAY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL MEDICAL HISTORY**

Please circle the appropriate answer or fill in the appropriate information.

Gender: Male Female Ethnic Background: \_\_\_\_\_

If female, are you or could you be pregnant? Yes No Trimester? \_\_\_\_\_

Height \_\_\_\_\_ ft \_\_\_\_\_ in Weight \_\_\_\_\_ lbs

Rate your current health status: poor average good excellent

Do you smoke? Yes No How many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Did you smoke in the past? Yes No When did you stop? \_\_\_\_\_ How much? \_\_\_\_\_

Do you drink alcohol? Yes No

How often? Daily 2-3x/week Weekends Rarely

How many drinks per session? 1 2 3 4 Greater than 4

Have you gained or lost weight over the past 5 years? Yes No

Gained \_\_\_\_\_ pounds Lost \_\_\_\_\_ pounds

Current and Past Medical Problems (Circle P for past, C for current)

Cardiac (heart)	Yes No	P C
Blood Pressure high/low	Yes No	P C
Stroke	Yes No	P C
Cancer Type _____	Yes No	P C
Pulmonary/Respiratory	Yes No	P C
Diabetes/Hypoglycemia	Yes No	P C
Urinary Tract/Renal	Yes No	P C
Gastrointestinal	Yes No	P C
Bleeding/Clotting	Yes No	P C
Neurologic	Yes No	P C
Psychiatric	Yes No	P C
Thyroid (Overactive/Underactive)	Yes No	P C
Allergies/ Hay Fever	Yes No	P C
Endocrine/Hormonal	Yes No	P C
Nasal/ Sinus	Yes No	P C
Throat/Voice/Hoarseness	Yes No	P C
Hearing Loss	Yes No	P C
Balance/Dizziness	Yes No	P C

**PLEASE TURN OVER AND COMPLETE NEXT PAGE**

**NEW/UPDATED MEDICAL HISTORY  
ADULT**

**OTHER SIGNIFICANT MEDICAL PROBLEMS** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? Yes No  
If yes, please list medication and nature of reaction: \_\_\_\_\_  
\_\_\_\_\_

List your current prescription medications and doses: None  
Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Medication \_\_\_\_\_ Medication \_\_\_\_\_

Do you use blood thinners such as Coumadin, Plavix, or aspirin? Yes No  
List: \_\_\_\_\_

Do you use other non-prescription medications? Yes No  
List: \_\_\_\_\_

Do you use vitamins, supplements, herbal remedies or alternative medications?  
Yes No List: \_\_\_\_\_

Have you had surgery at any time in the past? Yes No  
Surgery and Date: \_\_\_\_\_  
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Surgery and Date: \_\_\_\_\_

Is there other important information about your current health or past medical history that you would like us to know? Yes No  
Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY:**

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_