

**Welcome!**  
**We're Glad You're Here!**

We will do everything possible to make your visit a pleasant one. We want you to be as comfortable as possible. We take pride in our ability to render the finest in medical care.

**OPTIMAL OVERALL  
HEALTH & LONGEVITY**

Our goal is to provide the highest quality health care to all who seek it. We emphasize

“seek” because your cooperation is essential if we are to provide the care you deserve. Simplified, people can be healthy, attractive and energetic even into their 90's when health maintenance for the whole being is practiced. Preventive and anti-aging principles are the key to looking and feeling good. Let us show you how!

**CANCELLATIONS**

If you must cancel, please inform us at least **24 hours in advance** so that we may accommodate other patients. A missed appointment fee will be charged for “no shows” and last minute cancellations.

**INSURANCE & FEES**

Our Office welcomes insurance but payment is expected at the time of service for all deductibles, co-pays and co-insurance. Our office accepts credit cards for your convenience. Whenever you request us to render a service there will be a **CHARGE** to you or your insurance company.

When you have an urgent need, but we cannot accommodate you for an office visit, a telephone consultation may be done to render immediate treatment. The rate for this service, which is not covered by insurance, is \$3.00 per minute. This will be put on our schedule and a bill will be generated for the services provided. We will always attempt to forward these charges to your insurance company. For Self-Pay Patients, a menu of service charges is posted at our front desk.

**OFFICE HOURS**

<b>Monday</b>	<b>9:00 AM to 2:00 PM</b>
<b>Tuesday</b>	<b>9:00 AM to 2:00 PM</b>
<b>Weds</b>	<b>Closed</b>
<b>Thursday</b>	<b>9:00 AM to 2:00 PM</b>
<b>Friday</b>	<b>9:00 AM to 2:00 PM</b>
<b>Saturday</b>	<b>9:00 AM to NOON</b>



**Email Information:**

2frontdesk@gmail.com

**Appointment Request:**

2frontdesk@gmail.com

**Questions**

2frontdesk@gmail.com

**Joan Smith, D.O.**

**31664 Old Ocean City Road  
Salisbury, Maryland 21804**

**Phone : 410-334-3805**

**Fax: 410-860-5191**

## MISSION STATEMENT

The purpose of this Medical Practice is to:

- This is **NOT** a *Walk-In or Urgent Care Clinic*. Salisbury has other facilities for the treatment of sudden illness. Our office intends to provide long term preventive care to maintain the best possible level of good health for our patients. We will provide investigation and treatment for new illnesses that arise during our relationship together.
- This **IS** a wellness center for individuals who wish to take responsibility for maintenance of their personal health. We will offer you the best of our resources to help you achieve that goal. We strive continually to educate and encourage lifestyle changes which should lead to a healthier and longer life. We promote a healthy diet, regular exercise, stress reduction and healthful habits to help prevent disease and promote wellness.
- We do not believe in "5 Minute Medicine." We take great pride in our ability to render the finest medical care. Allowing us to review your Medical History and Insurance coverage will enable us to most completely meet your needs.

## IF YOU ARE A PATIENT NEW TO OUR OFFICE

New Patients will receive a Welcome Packet containing important information pertaining to your long term health care.

New Patients need to do the following:

- Provide a copy of their current insurance card, front and back.
- Fill out the medical questionnaire in the Welcome Packet.
- Sign a Medical Records Release Form for your records to be transferred to this office.
- Write a list of concerns to be addressed at your first appointment.

## HEALTH EXAMS

We attempt to provide our patients with 12 months of Maintenance medication at their annual health review. Yearly diagnostic testing is performed before prescribing long term medications, providing the

Physician with the best information to determine if any changes which may be needed. Medication will not be prescribed for patients who have not been seen in more than one year, an annual check must be scheduled. It is our joint responsibility to see that you are properly cared for and that your physical health is maintained.

Regular preventative recall visits promotes superior health.

# PATIENT INFORMATION FORM

*Joan Smith, DO; PA*

*Family Practice*

*31664 Old Ocean City Road*

*Salisbury, Maryland 21804*

*Phone: (410) 334-3805*

*Fax: (410) 860-5191*

*E-mail: 2frontdesk@gmail.com*

## ABOUT INSURANCE & FEES

Our office welcomes insurance, but payment is expected at the time of service for all Deductibles, Co-Pays and Co-Insurance. Our office accepts credit cards for your convenience. Whenever you request us to render a service there will be a CHARGE to you or your insurance company. When you have urgent need, but we cannot accommodate you for an office visit, a telephone consultation may be done to render immediate treatment. The rate for this service is \$3.00 per minute. This will be put on our schedule and a bill will be generated for the services provided. We will always attempt to forward these charges to your insurance company. For Self-Pay patients, a menu of service charges is posted at our front desk.

<b>DATE:</b>		<b>SOCIAL SECURITY NUMBER</b>		<b>REFERRED BY:</b>	
<b>NAME:</b>	<b>LAST</b>	<b>FIRST</b>	<b>MIDDLE</b>	<b>HOME PHONE:</b>	
<b>ADDRESS:</b>		<b>CITY:</b>		<b>STATE:</b>	<b>ZIP:</b>

**MAY WE HAVE YOUR E-MAIL ADDRESS SO THAT WE CAN SEND YOU PERSONAL INFORMATION, SUCH AS TEST RESULTS? Yes or No E-MAIL ADDRESS:**

<b>SEX</b> M / F	<b>AGE:</b>	<b>D.O.B.</b>	<b>MARITAL STATUS:</b> M S W D	<b>NUMBER OF CHILDREN:</b>	
<b>YOUR OCCUPATION:</b>		<b>YOUR EMPLOYER:</b>		<b>YOUR SUPERVISOR</b>	
<b>YOUR EMPLOYER'S ADDRESS:</b>		<b>CITY, STATE, ZIP</b>		<b>EMPLOYER'S PHONE</b>	
<b>EMERGENCY CONTACT NAME:</b>			<b>RELATIONSHIP</b>	<b>PHONE:</b>	
<b>NAME OF PARENT / GUARDIAN (if patient is a minor):</b>				<b>RELATIONSHIP</b>	

## IF YOU HAVE INSURANCE, PLEASE FILL OUT THE FOLLOWING:

<b>INSURED'S NAME:</b>		<b>INSURED'S SOC. SEC. #</b>	<b>INSURED'S D.O.B.</b>
<b>INSURED'S EMPLOYER'S ADDRESS:</b>		<b>CITY, STATE, ZIP</b>	<b>EMPLOYER'S PHONE</b>

## PLEASE LIST ANY ADDITIONAL MEMBERS ON INSURED'S CARD

<b>NAME</b>	<b>RELATION</b>	<b>SOCIAL SECURITY #</b>	<b>D.O.B.</b>
<b>NAME</b>	<b>RELATION</b>	<b>SOCIAL SECURITY #</b>	<b>D.O.B.</b>
<b>NAME</b>	<b>RELATION</b>	<b>SOCIAL SECURITY #</b>	<b>D.O.B.</b>
<b>NAME</b>	<b>RELATION</b>	<b>SOCIAL SECURITY #</b>	<b>D.O.B.</b>

**PLEASE OFFER A COPY OF YOUR INSURANCE CARD TO THE FRONT DESK.**

HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES / EXAMS? Please include the year and Physician (if known).						
PROCEDURE	DATE			PROCEDURE	DATE	
CATARACT SURGERY		Y	N	HERNIA REPAIR		Y N
TONSILLECTOMY		Y	N	HIP REPLACEMENT		Y N
APPENDECTOMY		Y	N	KNEE REPLACEMENT		Y N
GALLBLADDER (CHOLECYSTECTOMY)		Y	N	HEART SURGERY		Y N
HYSTERECTOMY		Y	N	BREAST EXAM		Y N
GYNECOLOGICAL EXAM		Y	N	MAMMOGRAM		Y N
RECTAL EXAM		Y	N	PROSTATE EXAM		Y N
PHYSICAL EXAM		Y	N	SIGMOIDOSCOPY / COLONOSCOPY		Y N
PLEASE DESCRIBE YOUR EXPERIENCES WITH THE FOLLOWING						
COFFEE		Y	N	EXERCISE PATTERNS		Y N
TOBACCO		Y	N	SEATBELT USE		Y N
ALCOHOL		Y	N	COUNSELING		Y N
SLEEP PATTERNS		Y	N	HAZARDOUS ACTIVITIES		Y N
FAMILY HISTORY						
RELATION			INFORMATION			
FATHER						
MOTHER						
BROTHERS / SISTERS						
SPOUSE						
CHILDREN						
DO YOU HAVE, OR IS THERE A FAMILY HISTORY OF THE FOLLOWING (please list type and relative)						
CONDITION	RELATIVE			CONDITION	RELATIVE	
CANCER		Y	N	STROKE		Y N
TUBERCULOSIS		Y	N	EPILEPSY		Y N
DIABETES		Y	N	MENTAL ILLNESS		Y N
HIGH BLOOD PRESSURE		Y	N	SUICIDE		Y N
HEART PROBLEMS		Y	N			
ADDITIONAL HISTORY						

**Assignment of Benefits and Release of Medical Information**

By signing below I authorize Joan Smith, D.O.; P.A. and her staff to submit medical claims to my insurance company commencing from the date indicated below. Additionally, I authorize payment of medical benefits directly to Joan Smith, D.O.; P.A. for those same services rendered.

By signing below I authorize the release of any medical information needed to process claims through my insurance company for services rendered while under Dr. Smith's care.

\_\_\_\_\_

Please include a copy of your insurance card(s).

Front

Back

JOAN SMITH, D.O.; P.A.



*Family Practice*  
31664 Old Ocean City Road  
Salisbury, MD 21804-1800

PATIENT NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I AUTHORIZE \_\_\_\_\_ TO RELEASE ANY AND ALL

MEDICAL RECORDS TO:           Joan Smith DO; PA  
  31664 OLD OCEAN CITY ROAD  
  SALISBURY, MARYLAND 21804-1800

PATIENT SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_

- MAILED AT PATIENT REQUEST TO THE ABOVE DOCTOR'S OFFICE
- PICKED UP BY PATIENT

*Phone: (410) 334-3805*  
*Fax: (410) 860-5191*  
*Email: 2frontdesk@gmail.com*