



JOHNS HOPKINS
M E D I C I N E

A T K E S W I C K

702 West 40th Street
Baltimore, Maryland 21211
410-467-6735

Dear new patients and Families,

Welcome to Johns Hopkins at Keswick, Johns Hopkins Medicine's newest physician office. Located on the Keswick Multi-Care Center campus in North Baltimore, Johns Hopkins at Keswick brings the specialized knowledge, compassionate care, and deep resources of its nationally recognized program for older adults' right to your doorstep.

PLEASE COMPLETE THE FOLLOWING ENCLOSED FORMS.

- (1) RELEASE OF MEDICAL RECORDS FORM: COMPLETE, SIGN AND MAIL OFF TO YOUR CURRENT DOCTORS/HOSPITALS WHERE YOU HAVE BEEN A PATIENT WITHIN THE LAST TWO YEARS.
- (2) NEW PATIENT ASSESSMENT PACKET AND MANUAL OUTPATIENT REGISTRATION FORM.

IF TIME PERMITS, MAIL THESE FORMS IN THE ENCLOSED ENVELOPE BACK TO JOHNS HOPKINS AT KESWICK.

On the day of your visit please bring the following:

- All medications (prescription, over the counter, herbal) you take daily
- All canes, walkers used on a daily basis
- All insurance cards

Thank you for your kind cooperation. We look forward to seeing you.

Sincerely,

Jeremy Barron, MD
Medical Director



JOHNS HOPKINS MEDICINE

AT K E S W I C K

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Patient Information	Last _____ First _____ M.I. _____ Maiden _____ Sex _____ Marital Status _____ Race _____ Religion _____ Address _____ Apt. _____ City _____ State _____ Zip Code _____ Age _____ DOB ____/____/____ SSN _____ Home Phone _____ Occupation _____ Employer _____ Employer Phone Number _____ Are you a member of an Anatomical Donor Program? Yes or NO
Medical Records Information	Father's Last Name _____ First _____ Mother's Maiden Name _____ First _____
Next of Kin Information	Last _____ First _____ M.I. _____ Relationship to Patient _____ Employer _____ Phone _____ Address if different from patient Address _____ Home Phone _____ City _____ State _____ Zip Code _____
Insurance Information	Medicare # _____ Effective Date _____ Part A _____ Part B _____ Medicaid # _____ Suffix _____ Eff Dates from _____ to _____ Blue Cross # _____ Policy Holder _____ Group # _____ Commercial Ins _____ Policy # _____ No Insurance
Guarantor Information	Is Patient the Guarantor? YES or NO Relationship to Patient _____ Last _____ First _____ Middle _____ Address if different from patient Address _____ Phone # _____ City _____ State _____ Zip Code _____
Authorization	<p>In consideration of the admission and/or treatment of the above patient: I/We agree to pay Johns Hopkins at Keswick the applicable charges and professional fees accrued and to pay the balance in full. I/We assign to Johns Hopkins at Keswick and Johns Hopkins Medicine insurance benefits and will submit necessary claim forms to cover the amount due. I/we understand that I We have the responsibility for any unpaid amount.</p> <p>Patient / Guarantor _____ Date _____ Completed by _____ Date of Service _____</p> <p>Attach copies of : Both sides of Insurance Cards, Drivers License, and Social Security Card.</p>



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NEW PATIENT ASSESSMENT

PATIENT INFORMATION:

Patient's Name _____ DOB _____

Name of person filling out this form _____ Today's Date _____

How did you hear about this clinic _____

Reason for visit: (Circle One) Consult or Establish Primary Care

Comments or concerns about patient's HEALTH: _____

MEDICAL HISTORY:

Have you had any of the following conditions?	YES	NO	COMMENTS
Diabetes			
High Blood Pressure			
Heart Disease			
Stroke			
Memory Problems			
Cancer			
Emphysema			
Kidney Disease			
Pneumonia			
Arthritis			
Osteoporosis/Broken Bones			
Other (please list)			

Name: _____

**PLEASE BRING ALL YOUR CURRENT MEDICATIONS WITH YOU
PRESCRIPTION AND NON-PRESCRIPTION – USE BACK OF SHEET IF
NEEDED**

NAME OF MEDICATION	STRENGTH	HOW IT IS PRESCRIBED
MEDICATIONS ALLERGIES		COMMENTS

ADVANCE DIRECTIVES:

USE BACK OF SHEET IF NEEDED	YES	NO	COMMENTS
Have you appointed a durable power of attorney for health care decisions?			
Do you have a living will?			
If you were unable to make your own health care decisions, who would you trust to make these decisions on your behalf?	Name of Person _____ Address _____ Phone _____ Relationship _____		
Do you have any opinions about cardiac resuscitation, mechanical ventilation, feeding tubes or other medical interventions that your doctor should know about?			

Name: _____

HEALTH MAINTENANCE:

	DATE	YES	NO	COMMENTS
When was your last eye exam?				
When was your last dental exam?				
Have you taken the pneumonia vaccine?				
Do you take the yearly flu shot?				
Has your stool been checked for blood?				
Have you had a sigmoidoscopy or colonoscopy?				
Has your cholesterol been checked?				
Do you engage in any exercise?				
Do you follow any special diet?				
Has your bone mineral density been measured?				
FOR WOMEN				
When was your last mammogram/breast exam?				
When was your last pelvic exam/pap smear?				
Have you ever taken hormones, i.e., estrogen?				
FOR MEN				
When was your last prostate exam?				

FAMILY HISTORY:

PLEASE LIST CURRENT AGE AND HEALTH STATUS OF FAMILY MEMBERS (IF DECEASED, LIST AGE AT DEATH AND CAUSE)	
Mother	
Father	
Brother(s)	
Sister(s)	
Spouse	
Children	

Name: _____

SOCIAL HISTORY:

Education (highest grade completed)	
Work History	
Are you retired	If so, how long?
What is your current living situation?	Type of House? With Whom?
Do you smoke cigarettes?	Current: Past years, but quit Never:
Have any of your friends or relative died recently?	
Are you having any severe financial difficulties?	

FUNCTIONAL ASSESSMENT:

Do you have any problems with:	YES	NO	COMMENTS
Walking			
Leakage of urine or feces			
Bathing yourself			
Dressing yourself			
Feeding yourself			
Getting out of bed or chair			
Using the telephone			
Driving a car			
Using public transportation			
Doing your own shopping			
Doing your own cooking			
Doing your own cleaning			
Managing your own finances			
Taking your medications			

Name: _____

OVERALL HEALTH:

HOW DO YOU FEEL (CHECK ONE)? EXCELLENT () GOOD () FAIR () POOR ()

REVIEW OF SYSTEMS:

	YES	NO	COMMENTS
Have you had a recent change in your weight?			
Any episodes of falling?			
Problems with dizziness?			
Are you depressed, sad or feel blue?			
Any trouble sleeping?			
Have you had any problems with money?			
Problems with hearing?			
Problems with teeth or dentures?			
Any problems with cough?			
Chest pain, diarrhea, or change in bowel habits?			
Any problems with passing urine, leakage, or trouble starting your stream?			
Any problems with sexual function?			
Do you have any other symptoms or health concerns, which have not been mentioned on this form (please explain)?			

Reviewed by physician (Signature Required)