Arthritis Care Specialists of Maryland

DR. MELISSA HAWKINS-HOLT, MD, FACR, FAAP

DR. MOE T. ZAN, MD , FACR

To our patients: All co-pays and balances are due at the time of service. If your insurance requires a referral please makes sure you bring a copy with you.

Patient Registration:

Name:_____ Social Security #: _____

Street:_____ Date of Birth:_____ Marital Status:_____

City/State/Zip: _____ Home Phone: _____

Employer/School: _____ Work Phone: _____

Occupation: _____ Cell Phone: _____

E-MAIL: _____ Pharmacy: _____ Phone#_____

Party Responsible if Other Than Patient:

Policy Holder: _____ Social Security #: _____

Address: _____ Date of Birth: _____

Employer: _____

Primary Care Physician:

Name: _____ Address:_____

Phone: _____ Address con't:_____

Emergency Contact Person: _____

Advance Directives: (Circle One) No Yes Please provide copy if yes.

Medicare Authorization For Assignment of Benefits

I authorize payment of Medical Benefits to the above physician:

Signature:_____ Date:_____

I understand that I am personally responsible for any amounts not covered by my insurance for medical services rendered and charged for broken appointments. I hereby assign to the above physician all payments received by me, or my dependants for such medical services rendered that have not been paid in full.

Signature:_____ Date:_____

Written Notice of Disclosure:

This notice is to inform all patients that this practice has a partial ownership and financial interest in a physician office lab and radiology service that is available to some patients. This clinical laboratory and radiology service may be used for testing if a valid need exists for the service. Any patient may choose to obtain these healthcare services from another health care entity.

Arthritis Care Specialists of Maryland

Patient History Form

Name:_____ _____ _____ _____ - Birth date: _____/_____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Date of first appointment: _____/_____/_____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Address: _____ _____ Age: _____ Sex: F [ ] M [ ]
STREET APT#

_____ Telephone: Home _____
CITY STATE ZIP Work _____

MARITAL STATUS: [ ] Never Married [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Spouse/Significant Other: [ ] Alive/Age ____ [ ] Deceased/Age Major Illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ _____ _____ Number of hour's worked/average per week _____

Referred here by: (check one) [ ] Self [ ] Family [ ] Friend [ ] Doctor [ ] Other Health Professional

Name of person making referral: _____

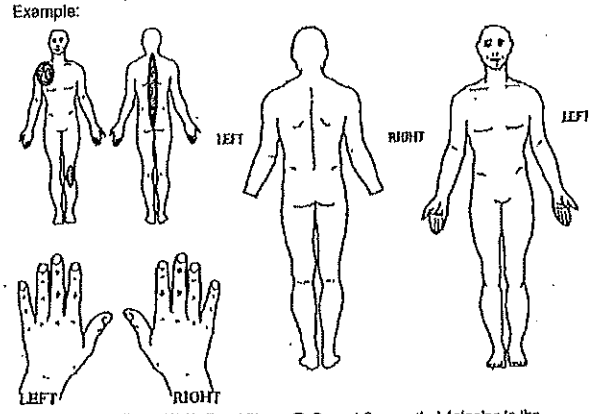
The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? [ ] Yes [ ] No If yes, Name: _____

Describe briefly your present symptoms: _____

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T, Current Comment - Listening to the patient - A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797808. Used by permission.

Date symptoms began (approximate):_____ Example

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

_____

Please list the names of other practitioners you have seen for this roblem:

_____

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			AnkYlosing Spondylitis	
	Childhood arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name _____ Date _____ Physician Initials _____

Arthritis Care Specialists
6350 Stevens Forest Rd. Suite 101
Columbia MD 21046

Adult Rheumatology
Pediatric Rheumatology

Notice of Privacy Practices

At Arthritis Care Specialists we have always kept your health information confidential. The law requires us to continue maintaining your privacy, and to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. We may use your health information to obtain payment from your insurance company, and/or to report your progress to them. We may use or disclose your healthcare information for our normal healthcare operations.

We may share your healthcare information with our business associates, such as our billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may call to remind you of your appointments, if you are not home, we may leave a message with this information on your answering machine. We may use your information to contact you.

If the practice is sold, your information will become the property of the new owner unless the practice notifies you otherwise.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You have the right to transfer copies of your health information to another practice. We will mail your files for you, after written authorization is obtained from you.

You have the right to see and obtain copies of your healthcare information, after written authorization is obtained.

You have the right to request your health information be amended or changed. You must request amendments or changes in writing. You have the right to copies of your health information. Written authorization must be obtained before copies can be released. We may charge you a reasonable fee for this service.

You have a right to receive a copy of this notice. If this practice changes the details of this notice, you will be notified in writing.

Acknowledgement: I have received a copy of the Notice of Privacy Practices from Arthritis Care Specialists

Signed: _____ **Print Name:** _____

Date:_____ **If signing as a parent or guardian, please provide the patient name:**

_____

Arthritis Care Specialists of Maryland
6350 Stevens Forest Rd. Suite 101
Columbia MD 21046

Adult Rheumatology
Pediatric Rheumatology
Physical Medicine/Pain Management

Office Billing Policy

1. Payment is due at the time of service unless other arrangements have been made in advance.

2. For those patients who sign an Assignment of Benefit form and the insurance companies pay us directly, a co-payment will be required at the time of the office visit.

3. An interest of 1.5 % per month will be added to patients' balance 30 days after insurance payment is received, should there be no payment or arrangements for payment previously worked out with the office.

4. For those patients with outstanding balances, it is the patient's responsibility to contact the office and make payment arrangements that are mutually agreed upon. In the event full payment or payment arrangements are not made, after 90 days, accounts will be forwarded to a collection agency.

5. Missed appointments will be subject to a $55.00 charge for new patients, and a $25.00 charge for follow-up patients unless reasonable notice (24 hours) is given, or an appropriate explanation is obtained.

6. Any checks returned will be subject to a returned check fee.

7. If for any reason your services are sent to collections or litigation there will be an additional fee added to your bill. Patients sent to the collection agency may be subject to dismissal from the practice. Patients being dismissed will be given 30 days to acquire a new Rheumatologist.

Balances and co-payments may be made payable by cash, check, or credit card. The office will be happy to discuss any questions at the patient's request. We look forward to providing you with quality health care.

Patient Signature: _____ Date: _____

Revised September 2010

Arthritis Care Specialists of Maryland

Adult Rheumatology Pediatric Rheumatology
6350 Stevens Forest Rd., Suite 101, Columbia, MD 21046

Phone (410) 992-7440 Fax (410) 992-4441

Stephen W. George, MD, FACR, FAAP Thomas J. Lang, MD, PhD, FACR Melissa Hawkins-Holt, MD, FACR, FAAP
Moe T. Zan, MD, FACR Marlyn Lorenzo, MD, FACR Shabnam Ali, MD, FACR David Arconti, C-PA Alyssa Metzler, C-PA

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

We are also participating with Surescript Care Quality Record Locater Service.
If you do not want to participate you can call our office and opt-out.

DISCLOSURE TO FAMILY/FRIENDS
TREATMENT AUTHORIZATION

___ I do not want Arthritis Care Specialists of Maryland ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

___ I Authorize Provider to disclose information related to my care and treatment to the following individuals

_____

_____

_____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ☐ Recent weight gain
  amount _____
- ☐ Recent weight loss
  amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ☐ Yes ☐ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ☐ Yes ☐ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ☐ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal (Miacalcin, Calcimar)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid (Benemid)		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others					
Tamoxifen (Nolvadex)		☐	☐	☐	
Tiludronate (Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc Injections		☐	☐	☐	
Herbal or Nutritional Supplements		☐	☐	☐	
Please list supplements:					

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, list: _____

_____

_____

_____

_____

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past -- How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No
If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Rheumatic fever _____	☐ Tuberculosis _____
☐ Leukemia _____	☐ High blood pressure _____	☐ Epilepsy _____	☐ Diabetes _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Asthma _____	☐ Goiter _____
☐ Colitis _____	☐ Alcoholism _____	☐ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

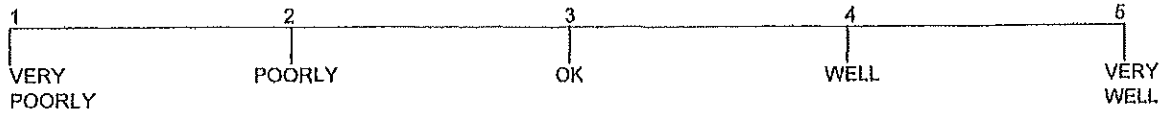
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	☐	☐	☐
Walking?	☐	☐	☐
Climbing stairs?	☐	☐	☐
Descending stairs?	☐	☐	☐
Sitting down?	☐	☐	☐
Getting up from chair?	☐	☐	☐
Touching your feet while seated?	☐	☐	☐
Reaching behind your back?	☐	☐	☐
Reaching behind your head?	☐	☐	☐
Dressing yourself?	☐	☐	☐
Going to sleep?	☐	☐	☐
Staying asleep due to pain?	☐	☐	☐
Obtaining restful sleep?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐
Working?	☐	☐	☐
Getting along with family members?	☐	☐	☐
In your sexual relationship?	☐	☐	☐
Engaging in leisure time activities?	☐	☐	☐
With morning stiffness?	☐	☐	☐
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	☐	☐	☐

What is the hardest thing for you to do?_____

Are you receiving disability?	Yes ☐	No ☐
Are you applying for disability?	Yes ☐	No ☐
Do you have a medically related lawsuit pending?	Yes ☐	No ☐

Patient's Name _____ Date _____ Physician Initials _____

Health Assessment Questionnaire-Disability Index

STANFORD UNIVERSITY SCHOOL OF MEDICINE, DIVISION OF IMMUNOLOGY AND RHEUMATOLOGY

Name _____ Date _____

The following questions are designed to help us assess how your illness affects your ability to function in daily life.

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty 0	With SOME difficulty 1	With MUCH difficulty 2	Unable to do 3	This column for physician use only: HIGHEST score
Dressing and Grooming					
Are you able to: —Dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐	
—Shampoo your hair?	☐	☐	☐	☐	
Arising					
Are you able to: —Stand up from a straight chair?	☐	☐	☐	☐	
—Get in and out of bed?	☐	☐	☐	☐	
Eating					
Are you able to: —Cut your meat?	☐	☐	☐	☐	
—Lift a full cup or glass to your mouth?	☐	☐	☐	☐	
—Open a new milk carton?	☐	☐	☐	☐	
Walking					
Are you able to: —Walk outdoors on flat ground?	☐	☐	☐	☐	
—Climb up five steps?	☐	☐	☐	☐	

Please mark "x" in any AIDS or DEVICES that you usually use for any of these activities:

- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Devices used for dressing (button hook, zipper pull, long shoehorn, etc)
- ☐ Built-up or special utensils
- ☐ Special or built-up chair
- ☐ Other (Specify): _____

SUBTOTAL Bring to top of next page

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

Continued on other side ▶

Please mark "x" in the response that best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty 0	With SOME difficulty 1	With MUCH difficulty 2	Unable to do 3
Hygiene				
Are you able to: —Wash and dry your body?	☐	☐	☐	☐
—Take a tub bath?	☐	☐	☐	☐
—Get on and off the toilet?	☐	☐	☐	☐
Reach				
Are you able to: —Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
—Bend down and pick up clothing from the floor?	☐	☐	☐	☐
Grip				
Are you able to: —Open car doors?	☐	☐	☐	☐
—Open jars which have been previously opened?	☐	☐	☐	☐
—Turn faucets on and off?	☐	☐	☐	☐
Activities				
Are you able to: —Run errands and shop?	☐	☐	☐	☐
—Get in and out of a car?	☐	☐	☐	☐
—Do chores such as vacuuming or yard work?	☐	☐	☐	☐

This column for physician use only

SUBTOTAL From bottom of page 1

HIGHEST score

Please mark "x" in any AIDS or DEVICES that you usually use for any of these activities:

- ☐ Raised toilet seat
- ☐ Bathtub seat
- ☐ Jar opener (for jars previously opened)
- ☐ Bathtub bar
- ☐ Long-handled appliances for reach
- ☐ Long-handled appliances in bathroom
- ☐ Other (Specify): _____

Total ÷

Please mark "x" in any categories for which you usually need HELP FROM ANOTHER PERSON:

- ☐ Hygiene
- ☐ Reach
- ☐ Gripping and opening things
- ☐ Errands and chores

Number of answered groups =

Total HAQ Disability Score

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness IN THE PAST WEEK:

NO PAIN — SEVERE PAIN

0 — 100

PLACE A VERTICAL (|) MARK ON THE LINE TO INDICATE THE SEVERITY OF THE PAIN.

Total Pain Score

Abbott
A Promise for Life

DIRECTIONS TO 6350 STEVENS FOREST RD., SUITE 101

From I 95, take exit for Route 32 West. In 2.5 miles, take exit for Route 29 North. Take exit for Broken land Parkway East and make first right turn onto Stevens Forest Road. We are in the large brick medical building on the right side, just past the gas station.

From West Baltimore, take 695 to I 70 West. Take exit for Route 29 South. In about 6 miles, take exit for Broken Land Parkway and stay to the right to go east. Make right at the first traffic light onto Stevens Forest Rd. We are in the large brick medical building on the right side, just past the gas station.

From Clarksville,Sykesville, Eldersburg or Westminister, take Route 32 South (past Clarksville) to Route 29 North. Take exit for Broken Land Parkway East. Turn right at the first light onto Stevens Forest Rd. We are in the large brick medical building on the right side, just past the gas station.

From Frederick, Take I 70 East to Route 32 South. Take exit for Route 29 North. Take exit for Broken Land Parkway East. Turn right at the first light onto Stevens Forest Rd. We are in the large brick medical building on the right side, just past the gas station.

From Silver Spring, take Route 29 north. Take exit for Broken Land Parkway East. Turn right at the first light onto Stevens Forest Rd. We are in the large brick medical building on the right side, just past the gas station.

From Bay Bridge or Annapolis, take Route 50 West to 97 North to Route 32 West to Route 29 North. Take exit for Broken Land Parkway East. Turn right at the first light onto Stevens Forest Rd. We are in the large brick medical building on the right side, just past the gas station.