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**Virginia Heartburn & Hernia Institute**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION FORM**  ***(Please make sure to print clearly and sign at the bottom of this page)*** | | | | | | | | | | | |
| Patient’s Last Name: First: Middle Initial: | | | | | | | Marital Status:  Married  Single  Widowed  Divorced | | | | |
| Birthdate: | Social Security Number: | | | | | | | | Sex: Male Female | | |
| Street Address: Apt# | | | | City: | | | | | | State: Zip Code: | |
| Home Phone: | | Work Phone: | | | | | | Cell Phone: | | | |
| Email Address: | | | | | Preferred Method of Contact: | | | | | | |
| Email Phone Mail | | | | | | |
| Race: Decline | | | | | Ethnicity: Hispanic or Non-Hispanic  Preferred Language: \_\_\_\_\_ | | | | | | |
| Asian Black Hispanic White  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Referring Dr. **(Full Name)**  Phone Number: | | | | | Primary Care Dr. **(Full Name)**  Phone Number: | | | | | | |
| Occupation: | | | | | Employer: | | | | | | |
| Emergency Contact & Number: | | | | | Relationship: | | | | | | |
| Preferred Pharmacy Name & Number: | | | | | **Consent to retrieve medication history?**  **Yes**  **No** | | | | | | |
| How did you hear about our practice?: Internet/Media Family/Friend Physician Referral Other:\_\_ | | | | | | | | | | | |
| **INSURANCE INFORMATION**  ***(PLEASE PRESENT ALL INSURANCE CARDS AND A PHOTO ID TO THE RECEPTIONIST)*** | | | | | | | | | | | |
| Primary Insurance: | | | | | | Member ID#: | | | | | |
| Group ID# | | | | | |
| Subscriber’s Name: | | | | | | Relationship: | | | | | |
|  | | | | | |  | | | | | |
| Subscriber’s Social Security #: | | | | | | DOB: | | | | | |
| Secondary Insurance: | | | | | | Member ID#: | | | | | |
| Group ID# | | | | | |
| Subscriber’s Name: | | | | | | Relationship: | | | | | |
| Subscriber’s Social Security #: | | | | | | DOB: | | | | | |
| **Responsible Party(If same as patient- you do not need to fill this portion out)** | | | | | | | | | | | |
| Name: | | | Address: | | | | | | | | Relationship: |
| Social Security #: | | |
| **By signing here, I attest that the above information is true and accurate to the best of my knowledge.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient/Guardian Signature Date** | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Questionnaire Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | |
| **Social History:**  Are you a current smoker?  Yes  No Have you ever been a smoker?  Yes  No  Do you drink alcohol?  Yes  No If so, how often to do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you currently use any recreational drugs?  Yes  No If yes, for how long have you been using? \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **CURRENT MEDICATIONS:** *(please list all medications, including those without a prescription)* | | | | | | | | | | | | | | | | | | | | | |
| ***Medication:*** | | | ***Dosage:*** | | | | | | | ***Medication:*** | | | | | | | | ***Dosage:*** | | | |
| 1. | | |  | | | | | | | 6. | | | | | | | |  | | | |
| 2. | | |  | | | | | | | 7. | | | | | | | |  | | | |
| 3. | | |  | | | | | | | 8. | | | | | | | |  | | | |
| 4. | | |  | | | | | | | 9. | | | | | | | |  | | | |
| 5. | | |  | | | | | | | 10. | | | | | | | |  | | | |
| **ALLERGIES: (please list)** | | | | | | | | | | | | | | | | | | | | | |
| ***Drug:*** | | ***Reaction/Symptoms:*** | | | | | ***Environmental:*** | | | | | | | | | | | | ***Reaction:*** | | |
| 1. | |  | | | | | Latex Allergy? | | | | | | | | | Yes  No | | |  | | |
| 2. | |  | | | | | Iodine Containing Components? | | | | | | | | | Yes  No | | |  | | |
| 3. | |  | | | | | IV Dye? | | | | | | | | | Yes  No | | |  | | |
| 4. | |  | | | | | Food? | | | | | | | | | | | |  | | |
| 5. | |  | | | | | Other: | | | | | | | | | | | |  | | |
| 6. | |  | | | | | **Metal Allergy?** | | | | | | | | | Yes  No | | |  | | |
| **ADDITIONAL HISTORY:** | | | | | | | | | | | | | | | | | | | | | |
| VRE | | | Clostridium Difficile | | | | | | | Hepatitis B | | | | | | | | Hepatitis C | | | |
| HIV Infection | | | MRSA | | | | | | | Tuberculosis | | | | | | | | Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **SURGERIES:** | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | | | | |  | Year: | | | | | | | |
| 2. | | | | | | | | | | | | |  | Year: | | | | | | | |
| 3. | | | | | | | | | | | | |  | Year: | | | | | | | |
| 4. | | | | | | | | | | | | |  | Year: | | | | | | | |
| 5. | | | | | | | | | | | | |  | Year: | | | | | | | |
| **REVIEW OF SYSTEMS:** | | | | | | | | | | | | | | | | | | | | | |
| **General:**  Feeling tired (fatigue)  Fever  Chills  Weight Loss  Weight Gain  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Head/ Ear/ Nose/ Throat:**  Recent change in taste  Nasal drainage  Snoring  Vision problems  Snoring  Postnasal drip  Hoarseness  Difficulty Swallowing  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Musculoskeletal:**  Muscle Weakness  Muscle Pain  Muscle Cramps  Osteoporosis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Psychiatric:**  Addiction  Anxiety  Depression  Hallucinations  Mania  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Endocrine:**  Adrenal Disorders  Diabetes Insipidus  Diabetes Mellitus Type 1  Diabetes Mellitus Type 2  Hyperthyroidism  Hypothyroidism  Goiter  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **Respiratory:**  Chronic Cough  Wheezing  Asthma  Bronchitis  Chest congestion  Chest tightness  Emphysema  Shortness of Breath  Tuberculosis Exposure  Sleep Apnea  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gastrointestinal:**  Abdominal Pain  Constipation  Belching  Diarrhea  Flatulence  Gastroesophageal Reflux  Heartburn  Nausea  Rectal Bleeding  Vomiting  Hiccups  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Dermatologic:**  Cellulitis  Skin Growths  Herpes Simplex  Lesions  Skin Cancer  Recurring Infections  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Hematologic:**  Anemia  Clotting Disorders  Prolonged Bleeding Time  Slow Wound Healing  Venous Thrombosis  Arterial Thrombosis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **Urologic:**  Painful urination  Flank pain  Urinary incontinence  Chronic/Acute Renal failure  Blood in urine  Impotence  Frequent urination  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Cardiovascular:**  Cardiovascular Disease  Congestive Heart Failure  Varicose Veins  Arrhythmia  Coronary Artery Disease  Hypertension  Myocardial Infraction  Peripheral Vascular Disease  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Neurologic:**  Seizures  Alteration of Consciousness  Sudden loss of Consciousness  Chronic Pain  Headaches/ Migraines  Confusion  Dizziness  Tremors  Memory Loss  Mental Status Change  Numbness  Muscle Weakness  Tingling Sensations  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **FAMILY HISTORY: Please**  **the box if there is a history in your family history.** | | | | | | | | | | | | | | | | | | | | | |
| **Member** | **Father** | | | | **Mother** | | | **Paternal Side** | | | | **Maternal Side** | | | | | **Children** | | | **Siblings** | |
| Status *(alive, deceased, unknown)* |  | | | |  | | |  | | | |  | | | | |  | | |  | |
| Y.O.B. |  | | | |  | | |  | | | |  | | | | |  | | |  | |
| Age |  | | | |  | | |  | | | |  | | | | |  | | |  | |
| Stroke | Yes  No | | | | Yes  No | | | Yes  No | | | | Yes  No | | | | | Yes  No | | | Yes  No | |
| Hypertension | Yes  No | | | | Yes  No | | | Yes  No | | | | Yes  No | | | | | Yes  No | | | Yes  No | |
| Cancer | Yes  No | | | | Yes  No | | | Yes  No | | | | Yes  No | | | | | Yes  No | | | Yes  No | |
| Diabetes | Yes  No | | | | Yes  No | | | Yes  No | | | | Yes  No | | | | | Yes  No | | | Yes  No | |
| Heart Disease | Yes  No | | | | Yes  No | | | Yes  No | | | | Yes  No | | | | | Yes  No | | | Yes  No | |
| Obesity | Yes  No | | | | Yes  No | | | Yes  No | | | | Yes  No | | | | | Yes  No | | | Yes  No | |
| **Please answer in the space provided:** | | | | | | | | | | | | | | | | | | | | | |
| Siblings: | Brothers | | |  | | | | | Sisters | |  | | | | | Healthy?  Yes  No | | | | | |
| Children: | Sons | | |  | | | | | Daughters | |  | | | | | Healthy?  Yes  No | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | |

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

**Printed Patient Name**  **Date**

**Patient Name: \_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_PATIENT FINANCIAL POLICY**

It is the responsibility of the patient to keep all insurance and demographic information up to date.

Co-payments are expected at the time of the visit as well as any deductibles, co-insurance payments, or payment for any non-covered services

If referral is required for your visit, it is the sole responsibility of each patient to arrive with that required referral. If you do not have the required referral at the time of your appointment, payment will be due at the time of service.

A fee of $30.00 will be assessed for returned checks.

I hereby authorize Virginia Heartburn & Hernia Institute to apply for benefits for services rendered. I certify that the information that I have provided with regard to insurance coverage is correct. I further authorize the release of any necessary information including medical information, for any related claim to my insurance carrier in order to determine benefits payable. I request that payment of authorized benefits be made payable to Virginia Heartburn & Hernia Institute.

I understand that I am financially responsible for the total charges for services rendered which may include non-covered services. I agree that all amounts are due upon request and are payable to Virginia Hospital Center Physician Group. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Virginia Hospital Center Physician Group.

I have read the above Patient Financial Policy and have provided true and correct insurance and demographic information. I will promptly notify you of any changes to my health insurance carrier, including new ID #’s with my current carrier.

**\_\_\_\_\_ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE**

By signing this form you acknowledge receipt of the Notice of Privacy for Virginia Heartburn & Hernia Institute. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full.

**\_\_\_\_\_ CONSENT FOR TREATMENT**

General Consent for treatment. I hereby authorize employees to render medical evaluations and care to the patient indicated below.

I acknowledge that according to Virginia state law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency virus (HIV), Hepatitis B, Hepatitis C viruses should any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, by directly exposed to my body fluids in connection with rendering care to the patient, in a manner which may, according to the current guidelines of the Center for Disease Control, transmit HIV, Hepatitis B, or Hepatitis C viruses. Test results may be released to the person exposed.

**2 .E- Prescribing Consent.** The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program.

By signing this consent form you are agreeing that this office can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

**3. Patient Information.** I authorize the practice to provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Print Person’s Name/Relationship) with information (including both medical and billing information) . This release will remain active in your electronic health record, and will not be cancelled unless there is written authorization from the patient to do so on file.

**\_\_\_\_\_ SURGERY CANCELLATION POLICY**

Scheduling of your operation requires a coordinated effort of multiple departments; beginning with your doctor and including the Hospital. Evaluation at the hospital by administrative, nursing, and anesthesia staff is also a time consuming and expensive period. Also authorization by your insurance carrier must be obtained for your operation.

Cancellation of surgery is sometimes unavoidable due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused operative time. Other patients who could have benefited from that operation time cannot do so unless the operative time is available soon enough.

Therefore, a minimum of **72 hours (3 business days)** notification is requires for surgery cancellation. This allows the physician and his staff to make arrangement to the schedule. If you must cancel your surgery, please call the office at 703-372-2280.

Failure to notify us of the cancellation in the required time will result in a charge of **$500.00**. This charge will be posted to your account.

*\* Exceptions to this policy will be made only for emergencies and conflicts beyond your control.*

I have read this policy and understand that cancellation of my surgery may results in a fee of **$500.00**.

**The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (please print) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient, Parent or Legal Guardian Date**

Contact information If Minor:

Family Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_home \_\_\_\_\_\_\_\_\_\_\_\_\_\_cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_ work

In the event we do contact you, is it suitable to leave a message(s) in the following manner (Check all that apply)

\_\_\_ on answering machine \_\_\_with an ADULT household member \_\_\_ exclusively with patient

Please circle: Cell Home or Other