Virginia Heartburn & Hernia Institute

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 ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other: _____	Ethnicity: ☐ Hispanic or ☐ Non-Hispanic Preferred Language: _____	
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:

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:

_____ _____ _____

Patient Signature **DOB** **Date**

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Belching
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Gastroesophageal Reflux
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Hiccups

If Yes, Explain:

_____

Respiratory:
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest congestion
- ☐ Chest tightness
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis Exposure
- ☐ Sleep Apnea

If Yes, Explain:

_____

Musculoskeletal:
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Muscle Cramps
- ☐ Osteoporosis

If Yes, Explain:

_____

Dermatologic:
- ☐ Cellulitis
- ☐ Skin Growths
- ☐ Herpes Simplex
- ☐ Lesions
- ☐ Skin Cancer
- ☐ Recurring Infections

If Yes, Explain:

_____

Cardiovascular:
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Varicose Veins
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Myocardial Infraction
- ☐ Peripheral Vascular Disease

If Yes, Explain:

_____

Urologic:
- ☐ Painful urination
- ☐ Flank pain
- ☐ Urinary incontinence
- ☐ Chronic/Acute Renal failure
- ☐ Blood in urine
- ☐ Impotence
- ☐ Frequent urination

If Yes, Explain:

_____

Hematologic:
- ☐ Anemia
- ☐ Clotting Disorders
- ☐ Prolonged Bleeding Time
- ☐ Slow Wound Healing
- ☐ Venous Thrombosis
- ☐ Arterial Thrombosis

If Yes, Explain:

_____

Psychiatric:
- ☐ Addiction
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Mania

If Yes, Explain:

_____

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

If Yes, Explain: _____

Endocrine:
- ☐ Adrenal Disorders
- ☐ Diabetes Insipidus
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Renal Failure

If Yes, Explain:

_____

Head/ Ear/ Nose/ Throat:
- ☐ Recent change in taste
- ☐ Nasal drainage
- ☐ Snoring
- ☐ Vision problems
- ☐ Postnasal drip
- ☐ Hoarseness
- ☐ Difficulty Swallowing

If Yes, Explain:

_____

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

If Yes, Explain:

_____

General:
- ☐ Feeling tired (fatigue)
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain

If Yes, Explain:

_____

_____ _____ _____

Patient Name **DOB** **Date**

Patient Name: _____ **DOB:** _____

(please initial next to each x)

x_____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 Heartburn & Hernia Institute. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Virginia Heartburn & Hernia Institute.

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.

x_____ 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.

x_____ 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.

x_____ 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
☐ Cell ☐ Home ☐ Other