

**Fauquier Health Physician Services, LLC
Hematology/Oncology**

Patient Name: _____ Date of Birth: _____

Past Medical History:

- | | | | | |
|--|--|---|---|---------------------------------------|
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Reflux/Gerd | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Herpes | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Vitamin D Deficiency | <input type="checkbox"/> Depression |

Other Medical History _____

Surgical History:

Surgery: _____ When: _____ Where: _____
 Surgery: _____ When: _____ Where: _____
 Surgery: _____ When: _____ Where: _____

Have you ever had a blood transfusion? _____

Current Medications (Include over the counter and prescribed medications):

Medication	Dosage / How Often	Medication	Dosage / How Often

Allergies:

Food Allergies? Yes No If yes, what? _____
 Medication Allergies? Yes No If yes, what? _____

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Family History:

Condition	Relationship	Condition	Relationship
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Dementia	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cystic Fibrosis	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Breast Cancer	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Down's Syndrome	_____
<input type="checkbox"/> Thyroid Disease	_____	<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Colon Cancer	_____	<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Stomach Disorders	_____	<input type="checkbox"/> Drug Abuse	_____

Other Family History _____

Reproductive History: (Female History Only)

Number of Pregnancies: _____ Full Term: _____ Premature: _____ Miscarriage / Abortion: _____
 Last Menstrual Period: _____ Method of Contraception: _____
 Last Mammogram: _____ Last Pap Smear: _____

Social History:

Do you use or have you used	Type	How Much	How Long	When quit
	Tobacco	_____	_____	_____
	Alcohol	_____	_____	_____
	Drugs	_____	_____	_____

Do you exercise? Yes No If yes, how often? _____

How many people live in your household? _____

Occupation: _____

Immunization History:

Date of Last Flu Shot: _____ Date of Last Pneumovax: _____
 Date of Last Tetanus: _____

Family Practice 6200 Station Drive Bealeton, VA 22712 Tel: 540-439-8100 Fax: 540-316-5582	Hematology/Oncology 500 Hospital Drive Warrenton, VA 20186 Tel: 540-316-4360 Fax: 540-316-5584	Internal Medicine 7915 Lake Manassas Drive Suite 101 Gainesville, VA 20155 Tel: 703-743-7300 Fax: 540-316-5581	Neurology 384 Hospital Drive Warrenton, VA 20186 Tel: 540-316-5980 Fax: 540-316-5583	Obstetrics & Gynecology 253 Veterans Drive Suite 210 Warrenton, VA 20186 Tel: 540-316-5930 Fax: 540-316-5585	Rheumatology Infectious Disease General Surgery Endocrinology Urology 550 Hospital Drive Warrenton, VA 20186 Tel: 540-316-5940 Fax: 540-316-5580
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Are you experiencing any of the following?

General:	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss
Eyes:	<input type="checkbox"/> Blurred Vision		
Head/ENT	<input type="checkbox"/> Congestion	<input type="checkbox"/> Cough	<input type="checkbox"/> Ear Pain <input type="checkbox"/> Sore Throat
Cardiovascular:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of Breath on Exertion
Respiratory:	<input type="checkbox"/> Shortness of Breath at Rest		
Gastrointestinal:	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Bloating	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Reflux	<input type="checkbox"/> Vomiting <input type="checkbox"/> Black Stool
Urinary/GYN	<input type="checkbox"/> Abnormal Periods	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Incontinence <input type="checkbox"/> Urgency
Skin:	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Rash	<input type="checkbox"/> Moles
Neurologic:	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Fainting	<input type="checkbox"/> Headaches <input type="checkbox"/> Seizures
Musculoskeletal:	<input type="checkbox"/> Cramping	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Soreness <input type="checkbox"/> Weakness
Endocrine:	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Hair Growth <input type="checkbox"/> Hot Flashes
	<input type="checkbox"/> Night Sweats		
Psychological:	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	
Heme-Lymph:	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	

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Hematology/Oncology
500 Hospital Drive
Warrenton, VA 20186
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Internal Medicine
7915 Lake Manassas Drive
Suite 101
Gainesville, VA 20155
Tel: 703-743-7300
Fax: 540-316-5581

Neurology
384 Hospital Drive
Warrenton, VA 20186
Tel: 540-316-5980
Fax: 540-316-5583

Obstetrics &
Gynecology
253 Veterans Drive
Suite 210
Warrenton, VA 20186
Tel: 540-316-5930
Fax: 540-316-5585

Rheumatology
Infectious Disease
General Surgery
Endocrinology
Urology
550 Hospital Drive
Warrenton, VA 20186
Tel: 540-316-5940
Fax: 540-316-5580

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Patient Name: _____ **Date of Birth:** _____

Contract for Services and Assignment of Benefits

In consideration of Fauquier Health Physician Services, LLC providing the patient named below with medical services, we the undersigned patient, sureties, and co-signers for the patient agree as follows:

- A. In connection with third party (insurance carriers, etc.) payment:
1. To authorize the practice to release information acquired in the course of examination and treatment for the purpose of insurance, Medicare and/or other insurance benefit payments.
 2. To further authorize payment directly to the practice of physician(s) accepting assignments for all medical benefits applicable and otherwise payable to the patient, but not to exceed the reasonable and customary charge for these services rendered by the physician(s).
 3. That we hereby certify that the information given by us in applying for insurance payment is correct, and request that said payment of authorized benefits be made on the patient's behalf.
 4. To authorize Fauquier Health Physician Services, LLC to act on the patient's behalf as attorney in fact in (1) the collection of benefits from any reasonable third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to me and/or the physician or practice.
- B. To guarantee payment of all charges of the patient whether or not an extension of time is granted for the payment of these charges or the practice accepts a note for the payment of these charges from either the patient or any third person or party.
- C. That payment for these services is due at the time of service.
- D. A charge of \$35.00 will be added to your account for non-sufficient funds each time your financial institution processes your transaction for payment.
- E. If for any reason you need to cancel or reschedule your appointment, we request that you notify the office within 24 hours of your scheduled appointment time. We reserve the right to charge a fee for appointments scheduled, but not kept. If you are more than fifteen minutes late for your scheduled appointment you may be rescheduled to another time and/or date. The fee for no show appointments is \$50.00.
- F. Please allow 24-48 hours for any prescription refill requests to be processed. Request authorizations and referrals a minimum of 48 hours in advance of your scheduled appointment or earlier for those insurance companies that require a longer timeframe.
- G. If this account should go into default you understand that you may be held liable for all reasonable collection fees and/or attorney fees incurred to collect this debt which may be up to 35% of the account balance.
- H. To pay all expenses incurred in collecting this account including reasonable attorney's fees and collection fees if this account is turned over to an attorney or collection agency for collection.

I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the health care provider it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia law, (Section 32.1-45.1 et.seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health providers are deemed to consent to tests and the release of the results to me should I be similarly exposed.

Patient/ Responsible Party

Date

Witness

Date

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Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Marital Status: _____ Ethnicity: _____ Race: _____

Email: _____ Preferred Pharmacy: _____

Reason For Visit: _____

Primary Care Provider: _____ Referring Provider: _____

How did you hear about us?

HIPAA Notice

Fauquier Health HIPAA Notice of Privacy Practices is available to you in its entirety in hard copy or on our web site, www.fhdoctors.org. I acknowledge that I have been offered Fauquier Health's Notice of Privacy Practices. Fauquier Health's Notice of Privacy Practices describes how medical information about you may be used and disclosed. It also explains how you can get access to this information, as well as who to contact if you feel your privacy rights have been violated.

Patient Signature

Date

Preferred Methods of Communications

In an effort to reach you more efficiently to confirm appointments, leave messages regarding your healthcare, and to discuss insurance billing issues, we are asking you to complete the following telephone contact information.

While we prefer NOT to leave messages, we would like to ensure that your medical information is properly protected as required by HIPAA guidelines. By completing the following telephone information, this will give us authorization to leave messages with those individuals listed at the numbers you have given below, if applicable.

Please list the names of family or friends with whom you authorize us to speak with relating to your medical care:

1.) _____ Relationship _____ Phone _____

2.) _____ Relationship _____ Phone _____

Please list the telephone numbers that are the best way for us to contact you :

Home: _____ Leave a message on machine: Yes No

Work: _____ Leave a message on machine: Yes No

Cell: _____ Leave a message on machine: Yes No

Please List Next of Kin

Name: _____ Relationship: _____

Address: _____ Phone: _____

Please List Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

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