As of: 4/8/2014

Fauquier Health Physician Services, LLC
Internal Medicine

Patient Name: _____ Date of Birth: _____

Past Medical History:

- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hypertension
- ☐ Asthma
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Reflux/Gerd
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Pancreatitis
- ☐ Seizures
- ☐ Stroke
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Glaucoma
- ☐ Anxiety
- ☐ 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 medication):

Medication	Dosage / How Often	Medication	Dosage / How Often

Allergies:

Food Allergies? ☐ Yes ☐ No **If yes, what?** _____

Medication Allergies? ☐ Yes ☐ No **If yes, what?** _____

Family History:

Condition	Relationship	Condition	Relationship
☐ Coronary Artery Disease		☐ Kidney Disease	
☐ Heart Attack		☐ Stomach Disorders	
☐ Heart Disease		☐ Dementia	
☐ Hypertension		☐ Migraines	
☐ Asthma		☐ Seizures	
☐ Cystic Fibrosis		☐ Stroke	
☐ Diabetes		☐ Osteoporosis	
☐ High Cholesterol		☐ Breast Cancer	
☐ Thyroid Disease		☐ Down's Syndrome	
☐ Colon Cancer			

Other Family History _____ _____ _____

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
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Fax: 540-316-5580

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Patient Name: _____ Date of Birth: _____

Reproductive History: (Female History Only)

Number of Pregnancies: _____ **Full Term:** _____ **Premature:** _____ **Miscarriage / Abortion:**

Last Menstrual Period: _____ **Method of Contraception:** _____

Social History:

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

Immunization History:

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

Are you experiencing any of the following?

General: ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Eyes: ☐ Blurred Vision

Head/ENT: ☐ Congestion ☐ Cough ☐ Ear Pain ☐ Sore Throat

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath on Exertion

Respiratory: ☐ Shortness of Breath at Rest

Gastrointestinal: ☐ Abdominal Pain ☐ Bloating ☐ Constipation ☐ Diarrhea

☐ Nausea ☐ Reflux ☐ Vomiting

Urinary/GYN: ☐ Abnormal Periods ☐ Frequent Urination ☐ Incontinence ☐ Urgency

Skin: ☐ Dry Skin ☐ Rash

Neurologic: ☐ Dizziness/Vertigo ☐ Fainting ☐ Headaches ☐ Seizures

Musculoskeletal: ☐ Cramping ☐ Joint Swelling ☐ Soreness ☐ Weakness

Endocrine: ☐ Cold Intolerance ☐ Excessive Sweating ☐ Hair Growth ☐ Hot Flashes

☐ Night Sweats

Psychological: ☐ Anxiety ☐ Depression

Heme-Lymph: ☐ Easy Bleeding ☐ Easy Bruising

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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.

That payment for these services is due at the time of service.

C. 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.

D. 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.

E. 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.

F. 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..

G. 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 simarly 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 website, 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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