

Patient Name: _____

Date of Birth: _____

Past Medical History:

- | | | | | |
|--|---|--|--|-------------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Reflux/Gerd | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Bleeding Disorder | <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 medication):

Medication	Dosage / How Often	Medication	Dosage / How Often

Allergies:

Food Allergies? Yes No If yes, what? _____

Medication Allergies? Yes No If yes, what? _____

Social History:

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

Family History:

Condition	Relationship	Condition	Relationship
<input type="checkbox"/> Coronary Artery Disease	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Stomach Disorders	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Dementia	_____
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Migraines	_____

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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|---|-------|---|-------|
| <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Cystic Fibrosis | _____ | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> High Cholesterol | _____ | <input type="checkbox"/> Breast Cancer | _____ |
| <input type="checkbox"/> Thyroid Disease | _____ | <input type="checkbox"/> Down's Syndrome | _____ |
| <input type="checkbox"/> Colon Cancer | _____ | <input type="checkbox"/> Uterine/Ovarian Cancer | _____ |
| Other Family History _____ | | | |

Reproductive History: (Female History Only)

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

Last Menstrual Period: _____ Method of Contraception: _____

Age of Onset of Menopause: _____ Number of Living Children: _____

History of: Abnormal Pap Infertility Abnormal Menstruation

Immunization History:

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

Date of Last TDap: _____

Are you experiencing any of the following?

- | | | | | | |
|--------------------------|---|--|-----------------------------------|--|---|
| <u>General:</u> | <input type="checkbox"/> Chills | <input type="checkbox"/> Fever | <u>Urinary/GYN:</u> | <input type="checkbox"/> Dysuria | <input type="checkbox"/> Frequent Urination |
| <u>Eyes:</u> | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Eye Pain | <u>Skin:</u> | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Rash |
| <u>Head/ENT:</u> | <input type="checkbox"/> Congestion | <input type="checkbox"/> Sore Throat | <u>Endocrine:</u> | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Polyuria |
| <u>Cardiovascular:</u> | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <u>Heme-Lymph:</u> | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising |
| <u>Respiratory:</u> | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of Breath | | | |
| <u>Gastrointestinal:</u> | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vomiting | | |

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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:
- 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.
 - 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).
 - 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.
 - 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 similarly exposed.

Patient/ Responsible Party

Date

Witness

Date

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Fauquier Health Physician Services, LLC
OB/GYN

As of: 4/8/2014

Patient Name: _____ Date of Birth: _____

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

Marital Status: _____ Ethnicity: _____ Race: _____

Email: _____ Preferred Pharmacy: _____

Reason For Visit: _____ How did you hear about us? _____

Primary Care Provider: _____ Referring Provider: _____

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: _____ No

Address: _____ Phone: _____

Please List Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

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