As of: 4/8/2014

# Fauquier Health Physician Services, LLC
# Rheumatology

Patient Name: ______________________ Date of Birth: ____________

## Rheumatology History:

| | Yourself | Relative | Relationship |
|---|---|---|---|
| Ankylosing Spondylitis | ☐ | ☐ | |
| Arthritis | ☐ | ☐ | |
| Childhood Arthritis | ☐ | ☐ | |
| Gout | ☐ | ☐ | |
| Lupus | ☐ | ☐ | |
| Osteoarthritis | ☐ | ☐ | |
| Osteoporosis | ☐ | ☐ | |
| Rheumatoid Arthritis | ☐ | ☐ | |

## Past Medical History:

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

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 |
|---|---|---|---|
| | | | |
| | | | |
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# Fauquier Health Physician Services, LLC
## Rheumatology

Patient Name: ______________________ Date of Birth: ______________

## Allergies:

Food Allergies? ☐ Yes ☐ No If yes, what? ______________________

Medication Allergies? ☐ Yes ☐ No If yes, what? ______________________

## Family History:

| Condition | Relationship | Condition | Relationship |
|---|---|---|---|
| ☐ Heart Attack | | ☐ Ankylosing Spondylitis | |
| ☐ Heart Disease | | ☐ Arthritis | |
| ☐ Hypertension | | ☐ Childhood Arthritis | |
| ☐ Asthma | | ☐ Gout | |
| ☐ Cystic Fibrosis | | ☐ Lupus or SLE | |
| ☐ Diabetes | | ☐ Osteoarthritis | |
| ☐ High Cholesterol | | ☐ Osteoporosis | |
| ☐ Thyroid Disease | | ☐ Rheumatoid Arthritis | |
| ☐ Colon Cancer | | ☐ Breast Cancer | |
| ☐ Kidney Disease | | ☐ Down's Syndrome | |
| ☐ Stomach Disorders | | ☐ Alcoholism | |
| ☐ Dementia | | ☐ Anxiety | |
| ☐ Migraines | | ☐ Depression | |
| ☐ Seizures | | ☐ Drug Abuse | |
| ☐ Stroke | | | |

Other Family History ______________ ______________ ______________

## 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 ofter? ______________

How many people live in your household? ______________

Occupation: ______________________

As of: 4/8/2014

# Fauquier Health Physician Services, LLC
# Rheumatology

**Patient Name:** ______________________ **Date of Birth:** ______________

## Immunization History:

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

**Date of Last Tetanus:** ______________ **Date of Last TB Test:** ______________

## Are you experiencing any of the following?

**General:** ☐ Fatigue ☐ Fever ☐ Weakness ☐ Weight Gain ☐ Weight Loss

**Eyes:** ☐ Dryness ☐ Loss of Vision ☐ Pain ☐ Redness

**Head/ENT** ☐ Difficulty Swallowing ☐ Dry Mouth ☐ Hearing Loss ☐ Hoarseness ☐ Loss of Taste ☐ Mouth Sores ☐ Sore Throat ☐ Nosebleeds

**Cardiovascular:** ☐ Chest Pain ☐ Swelling Legs/Feet

**Respiratory:** ☐ Cough ☐ Coughing Up Blood ☐ Difficulty Breathing at Night ☐ Shortness of Breath ☐ Snoring ☐ Stop Breathing at Night ☐ Wheezing

**Gastrointestinal:** ☐ Black Stool ☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Heartburn ☐ Vomiting Blood or Coffee Ground Material

**Urinary/GYN** ☐ Bloody Urine ☐ Vaginal Dryness

**Skin:** ☐ Color Changes in Hands or Feet in Cold ☐ Hair Loss ☐ Leg Ulcers ☐ Rash ☐ Redness ☐ Sun Sensitive

**Neurologic:** ☐ Memory Loss ☐ Sensitivity or Pain in Hands or Feet

**Musculoskeletal:** ☐ Joint Pain ☐ Joint Swelling ☐ Limited Range of Motion ☐ Morning Stiffness ☐ Muscle Tenderness ☐ Muscle Weakness

List joints affected in the last 6 months: ______________________

**Psychological:** ☐ Anxiety ☐ Depression ☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Excessive Worries

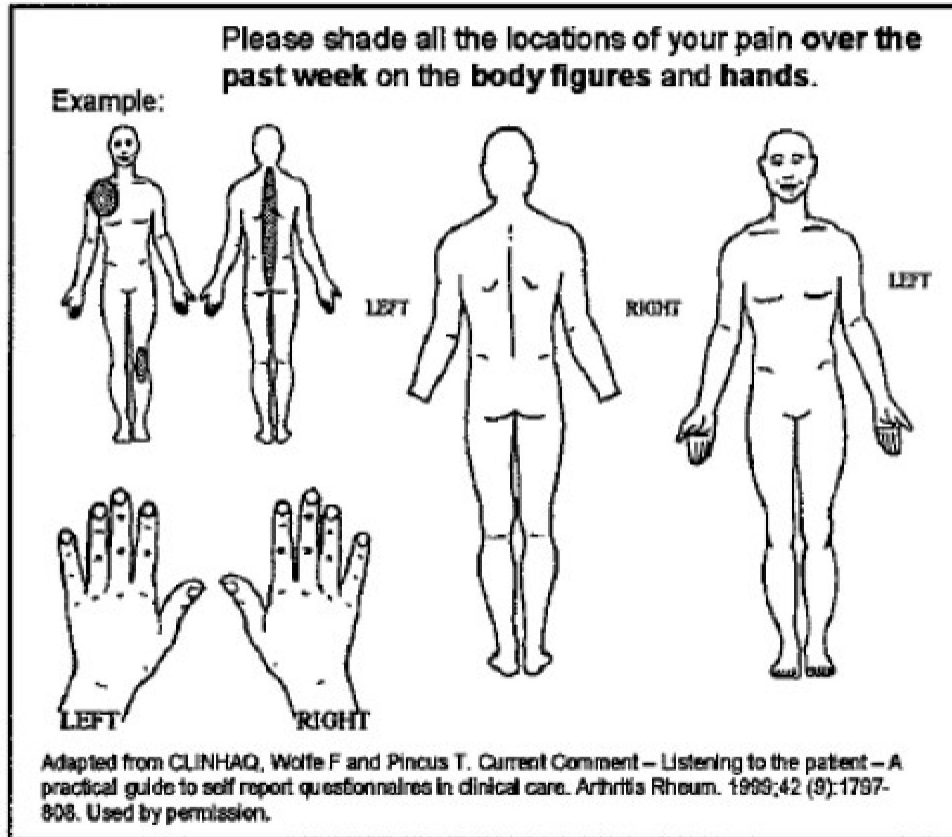
As of: 4/8/2014

# Fauquier Health Physician Services, LLC
## Rheumatology

**Patient Name:** ______________________________ **Date of Birth:** ____________________

**Heme-Lymph:** ☐ **Anemia** ☐ **Bleeding Tendency** ☐ **Swollen Glands** ☐ **Tender Glands**

**Allergic:** ☐ **Frequent Sneezing** ☐ **Increase Susceptibility to Infection**



**Fauquier Health Physician Services, LLC**
**Rheumatology**

**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.

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.

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. 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

As of: 4/8/2014

# Fauquier Health Physician Services, LLC
## Rheumatology

**Patient Name:** ______________________ **Date of Birth:** ______________

**Mailing Address:** ______________ **City:** ______________ **State:** X ______ **ZIP:** X ______________

**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: ______________