PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

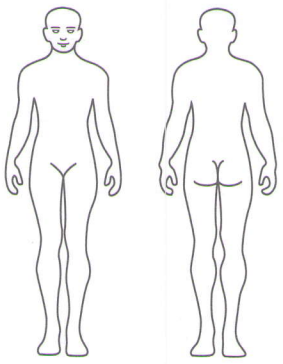
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE- PAST MEDICAL HISTORY
Advance Health Center

Name: _____ Date of Birth: _____ Age: _____ Date: _____

ALLERGIES

(List any allergies to medicines or other substances) ☐ None

SURGERY/HOSPITALIZATION

Date	Reason	☐ None

MEDICAL PROBLEMS

List any chronic or recurrent medical problems - Date of onset

☐ None

List All Medication You Take Regularly (Prescription and Non-Prescription)

Medicine	Dose	☐ None

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE:

Past/Current		Past/Current	
☐	☐ Abnormal Electrocardiogram	☐	☐ Heart Attack
☐	☐ Abnormal Pap Smear	☐	☐ Heart Murmur or Heart Disease
☐	☐ AIDS or HIV	☐	☐ Hepatitis or Cirrhosis
☐	☐ Alcohol/Drug Overuse/Abuse	☐	☐ Herniated or Ruptured Disc
☐	☐ Allergies or Hay Fever	☐	☐ Herpes
☐	☐ Anemia (low iron)	☐	☐ High Blood Pressure
☐	☐ Ankles swell frequently	☐	☐ Hodgkin's Disease, Lymphoma, or Leukemia
☐	☐ Anxiety or Panic Attacks	☐	☐ Intolerance of Dairy/Fatty Foods
☐	☐ Arthritis or Gout	☐	☐ Irregular Heartbeat
☐	☐ Asthma		
☐	☐ Frequent Backaches	☐	☐ Irritable Bowel Syndrome
☐	☐ Bladder Infection	☐	☐ Kidney Disease or Nephritis
☐	☐ Blood Clots or Bleeding Prob.	☐	☐ Kidney Stones
☐	☐ Blood in Bowel Movement	☐	☐ Lung Problems
☐	☐ Blood Transfusion	☐	☐ Lupus
☐	☐ Boils or Cysts - Recurrent	☐	☐ Malaria
☐	☐ Bone or Joint Disease	☐	☐ Seizures, Convulsions or Epilepsy
☐	☐ Bowel or Colon Disease	☐	☐ Meningitis
☐	☐ Breast Lumps	☐	☐ Migraine Headache
☐	☐ Bronchitis - Recurrent	☐	☐ Mole Changes
☐	☐ Bruise Easily	☐	☐ Muscle Disease or Weakness
☐	☐ Bursitis or Tendonitis	☐	☐ Pancreatitis
☐	☐ Cancer	☐	☐ Phlebitis
☐	☐ Chest Pain	☐	☐ Pleurisy
☐	☐ Chills or night sweats	☐	☐ Pneumonia
☐	☐ Cholesterol-Elevated	☐	☐ Polio
☐	☐ Chronic Cough	☐	☐ Problems with urination
☐	☐ Colitis	☐	☐ Rheumatoid Arthritis
☐	☐ Color-blindness	☐	☐ Rheumatic Fever
☐	☐ Concerns about fertility	☐	☐ Seizures, Convulsions or Epilepsy
☐	☐ Concussion or Head Injury	☐	☐ Sensory Changes
☐	☐ Constipation	☐	☐ Sexual Problems/Concerns
☐	☐ Depression or Suicide	☐	☐ Shortness of Breath
☐	☐ Diabetes	☐	☐ Sickle Cell Disease or Trait
☐	☐ Difficulty swallowing	☐	☐ Skin Disease - Chronic
☐	☐ Dizziness or Fainting	☐	☐ Skin Infections - Recurrent
☐	☐ Emphysema	☐	☐ Sleep Difficulties/Disorders
☐	☐ Excessive Stress	☐	☐ Sprains or Dislocations
☐	☐ Frequent colds/sinus problems	☐	☐ Stomach Pain
☐	☐ Frequent earaches	☐	☐ Stroke or Heart Attack
☐	☐ Frequent or painful urination	☐	☐ Swelling of joints
☐	☐ Frequent/severe sore throat	☐	☐ Thyroid Disease
☐	☐ Frequent/severe nosebleeds	☐	☐ Tremors/shaking of hands
☐	☐ Gallbladder Disease or Gallstone	☐	☐ Tuberculosis (TB) or positive test
☐	☐ Glaucoma	☐	☐ Ulcer Disease or Gastritis
☐	☐ Gonorrhea, Syphilis or Chlamydia	☐	☐ Unexpected weight loss
☐	☐ Growth on skin	☐	☐ Urinate frequently at night
☐	☐ Gum bleed easily	☐	☐ Varicose Veins
☐	☐ Frequent/severe sore throat	☐	☐ Venereal Disease
☐	☐ Hearing Problems	☐	☐ Wheezing or whistling chest
		☐	☐ Yellow Jaundice

IMMUNIZATION HISTORY

			DATE OF LAST
Chickenpox or Shot	☐ Yes	☐ No	
Hepatitis B Series or Shots	☐ Yes	☐ No	
Influenza Shot	☐ Yes	☐ No	
Pneumonia Shot	☐ Yes	☐ No	
Rubella Shot or Blood Test	☐ Yes	☐ No	
Tetanus Shot	☐ Yes	☐ No	

FAMILY HISTORY

	If Alive, Age	If Dead, Age and Cause
Father		
Mother		
Brother/Sister		
Spouse/Sig Other		
Son(s)/Daughter(s)		

PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE

Condition	Who
☐ Alcohol/Drug Abuse	
☐ Allergies/Asthma	
☐ Arthritis/Gout	
☐ Bleeding Disorder	
☐ Cancer (Type)	
☐ Diabetes	
☐ Epilepsy/Seizures	
☐ Glaucoma	
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ HIV/AIDS	
☐ Kidney Disease	
☐ Mental Illness	
☐ Migraine Headaches	
☐ Sickle Cell Condition	
☐ Stroke	
☐ Suicide/Depression	
☐ Thyroid Disease	
☐ Other	

SOCIAL HISTORY

My current status is:

With whom do you now live?

Highest education achieved?

Your Occupation?

Exposure to hazardous conditions/substances at work? ☐ No ☐ Yes

Type:

Religious preference/beliefs:

Do you have a living will? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes

PERSONAL HISTORY

QUESTIONS FOR WOMEN ONLY:

MENSTRUATION:

Age periods began: How often:

Date of last menstrual period:

Now Pregnant?	☐ Yes	☐ No
Vaginal Discharge?	☐ Yes	☐ No
PMS?	☐ Yes	☐ No
Menopause?	☐ Yes	☐ No
Unexplained Vaginal Bleeding?	☐ Yes	☐ No
Discharge from nipples?	☐ Yes	☐ No
Skin changes in breasts?	☐ Yes	☐ No

PREGNANCIES:

Total Number: Full Term:

Date of last Pap Smear:

Date of last mammogram:

Premature:

Miscarriages:

Abortions:

Tubal Pregnancies:

QUESTIONS FOR MEN

Prostate Trouble?	☐ Yes	☐ No
Discharge from penis?	☐ Yes	☐ No
Sore on penis?	☐ Yes	☐ No
Do you examine your testicles?	☐ Yes	☐ No

QUESTIONS FOR MEN AND WOMEN

What kind of Birth Control/Protection do you and/or your partner use?

How would you describe your sexual orientation?

Do you use sunscreen?	☐ Yes	☐ No
Do you always wear seatbelts?	☐ Yes	☐ No
Do you wear protective sports equipment?	☐ Yes	☐ No
Is your house a smoke-free house?	☐ Yes	☐ No
Do you have a working smoke detector?	☐ Yes	☐ No
Are there any guns/weapons in your home?	☐ Yes	☐ No
Do you floss your teeth regularly?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No

Last dental visit? Date:

Do you wear glasses/contacts? ☐ Yes ☐ No

Last eye exam? Date:

DIET & EXERCISE HABITS:

Do you follow a special diet? If so, explain:

Current Weight? Desired? One year ago?

What kind of exercise do you do and how often?

TOBACCO USE:

Do you smoke? What type:?

If yes, how much per day? Per week?

Have you quit smoking? When?

Do you use other tobacco products? Type:

If so, how much?

ALCOHOL USE:

Do you drink alcohol? How many drinks per week?

Has anyone ever expressed concerns about your alcohol use?

If yes, please explain:

Advanced Health Center

Patient Authorization for Disclosure of Health Information
(In case patient is not available)

(CHECK ONE OF THE OPTIONS BELOW)

☐ I **DO** authorize Advanced Health Center to use and/or disclose certain protected health information (PHI) about me to: _____.

This authorization permits **Advanced Health Center** to disclose individually identifiable health information in case patient is not available

- ☐ Date of visit
- ☐ Reason for visit
- ☐ Lab results
- ☐ Diagnostic test results
- ☐ Medications

☐ I **DO NOT** authorize Advanced Health Center to disclose any information other than myself.

When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to: **Advanced Health Center**

Signed by: _____
Signature of Patient or Legal Guardian

_____
Relationship to Patient

_____
Print Patient's Name

_____
Date

Advanced Health Center

46 South Glebe Road, Suite 100
Arlington, VA 22204
Tel: 703-521-0644

Treatment Consent and Financial Policy Agreement

Thank you for choosing our physicians for your health care needs. We are committed to providing the very best medical care and successful treatment. The following is a statement of our Treatment Authorization and Financial Policy which you must read, agree, and sign prior to treatment. Our Treatment Authorization and Financial Policy apply to all services by our physicians. In order to provide medical treatments and bill for your services, we must have you complete this form at least once a year.

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform our practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between and you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits, referrals and pre-authorization requirements.

Patient with Private Insurance: Our office will file claim(s) to the insurance companies we contract with, provided that you authorize the 'assignment of benefits' for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Self-Pay Patients: Patients without insurance coverage are expected to pay in full for services received at the time of service.

Consent for Treatment: I authorize medical treatments for myself or my minor child by physicians and medical assistants at Advanced Health Center.

Patient Payment Agreement: I understand that I am financially responsible to **Internal Medicine of Arlington / Advanced Back and Neck P.C.** for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, co-payments, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 75 days, the outstanding services will become my responsibility for immediate payment. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, or non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days from the date that the amount due is billed. I understand that failure to pay outstanding balances or make payment arrangements within 90 days will result in the amount due being considered delinquent and subject to legal action or assignment to a collection agency.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the treatment consent and financial policy stated above.

_____

Please Print Name of the Patient

_____ _____

Signature of Patient or Legal Guardian **Date**