

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DEMOGRAPHICS

LAST NAME		FIRST NAME		MIDDLE INITIAL	
SOCIAL SECURITY NUMBER		SEX		PREFIX/SUFFIX	
DATE OF BIRTH (mm/dd/yy)		STATUS (please circle one) Single Married Divorced Widowed Legally Separated Partner		STUDENT (please circle one) No Full-Time Part-Time	
STREET ADDRESS		CITY/STATE		ZIP CODE	
HOME PHONE (include area code)		CELL PHONE		WORK PHONE	
RACE (please circle one) American Indian/Alaska Native Hawaiian/Pacific Islander Black/African American Asian White Decline Response		ETHNICITY (please circle one) Hispanic or Latino Not Hispanic or Latino Unknown Decline Response		PREFERRED LANGUAGE English Spanish Other: _____	
EMPLOYER		JOB TITLE/STATUS		EMAIL ADDRESS	
PREFERRED PHARMACY		PHARMACY PHONE NUMBER		PHARMACY ADDRESS	

EMERGENCY CONTACT INFORMATION

CONTACT (please circle at least one) Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME		FIRST NAME		MIDDLE INITIAL	
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIONSHIP TO PATIENT		SEX	MARITAL STATUS		
HOME ADDRESS		CITY/STATE		ZIP CODE	HOME PHONE		
EMPLOYER		JOB TITLE		CELL PHONE		WORK PHONE	

GUARANTOR INFORMATION

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party

LAST NAME		FIRST NAME		MIDDLE INITIAL		
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIONSHIP TO PATIENT		SEX	MARITAL STATUS	
HOME ADDRESS		CITY/STATE		ZIP CODE	HOME PHONE	
EMPLOYER		JOB TITLE		CELL PHONE		WORK PHONE

INSURANCE POLICY INFORMATION

POLICY NUMBER		GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Worker's Comp. Other		PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: \$ _____ Specialist: \$ _____
NAME OF INSURANCE COMPANY/PLAN		INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME		DATE OF BIRTH (mm/dd/yy)	HOME PHONE	
INSURED'S MAILING ADDRESS			PRIMARY CARE PHYSICIAN (pcp) &/or REFERRING PHYSICIAN	

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER		GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Worker's Comp. Other		PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: \$ _____ Specialist: \$ _____
NAME OF INSURANCE COMPANY/PLAN		INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME		DATE OF BIRTH (mm/dd/yy)	HOME PHONE	

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Print Name

Date

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis

Date

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

Name: _____ Date of Birth: _____

PATIENT HISTORY

CURRENT MEDICATIONS: Are you taking any medications now? Yes No

If yes, please list **name** and **dosage** of the medicine. Include prescription, over the counter, natural, herbals:

Name of Medicine(s)	Dosage(if known)	Frequency

What is the **REASON** for today's visit? _____

ALLERGIES: Are you allergic to any **MEDICATIONS**? Yes No

If yes, please list the medication(s) and reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Have you **TRAVELLED OUTSIDE THE COUNTRY** recently? Yes No

If yes, please state where and when? _____ Date: _____

Did you receive any **IMMUNIZATIONS** other than **PRIMARY SERIES** (childhood vaccines)? Yes No

If yes, please list immunization(s): _____

Have you ever had a positive **TUBERCULOSIS TEST** or have had **HISTORY OF EXPOSURE**? Yes No

If yes, please explain: _____

Have you had any **BITES** or **RASHES** that required treatment by a physician? Yes No

If yes, please explain: _____

Please list all past **SURGERIES** and **HOSPITALIZATIONS** and the approximate date below:

Surgery/Hospitalization	Date (approximate)

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of the following? Yes No
 If yes, please circle the following that apply:

Acid Reflux	COPD	Headache	Thyroid Disorder
Allergic Rhinitis	Emphysema	Hearing Loss	Immunodeficiency
Anxiety Disorder	Depression	Hepatitis A, B or C	Sleep Apnea
Asthma	Deviated Septum	Herpes Zoster/Shingles	Tonsillitis
Bleeding Disorder	Diabetes Type I or II	High Blood Pressure	TMJ Disease
Cancer <small>TYPE:</small>	Ear Infections	High Cholesterol	Other:
Chronic Sinusitis	Renal Disease	HIV or AIDS	Other:

FAMILY HISTORY

Father		<input type="radio"/> Alive <input type="radio"/> Deceased	<input type="radio"/> Healthy <input type="radio"/> Medical Problems:
Mother		<input type="radio"/> Alive <input type="radio"/> Deceased	<input type="radio"/> Healthy <input type="radio"/> Medical Problems:
Brother (s)	#	<input type="radio"/> Alive <input type="radio"/> Deceased	<input type="radio"/> Healthy <input type="radio"/> Medical Problems:
Sister (s)	#	<input type="radio"/> Alive <input type="radio"/> Deceased	<input type="radio"/> Healthy <input type="radio"/> Medical Problems:
Son (s)	#	<input type="radio"/> Alive <input type="radio"/> Deceased	<input type="radio"/> Healthy <input type="radio"/> Medical Problems:
Daughter (s)	#	<input type="radio"/> Alive <input type="radio"/> Deceased	<input type="radio"/> Healthy <input type="radio"/> Medical Problems:

SOCIAL HISTORY

OCCUPATION: What is your occupation? _____

Full-time Part-time Student Unemployed Retired Other:

PETS: Do you have pets in the home? Yes No Dog Cat Bird Other:

SMOKING: Do you smoke cigarettes? Yes No # ___ Packs/Day? Former Smoker? Yes No

CHEWING TOBACCO: Do you chew tobacco? Yes No

ALCOHOL: Do you consume alcohol? Yes No Drinks per Week? 2 or less 3-5 >6

DRUGS: Do you use any recreational drugs? Yes No Former User? Yes No List:

HOME LIVING SITUATION: Alone w/Spouse w/Spouse & Kids w/Kids Other:

SEXUAL ORIENTATION: Heterosexual Same Sex Bisexual

Name: _____ Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Please indicate if you have any of the symptoms below, if no symptoms are present please mark **None**:

<p>GENERAL</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Fever<input type="radio"/> Chills<input type="radio"/> Fatigue<input type="radio"/> Weakness<input type="radio"/> Night sweats<input type="radio"/> Difficulty walking <p>SKIN</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Rash<input type="radio"/> Itching<input type="radio"/> Lumps <p>RESPIRATORY</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Cough<input type="radio"/> Sputum production<input type="radio"/> Coughing up blood<input type="radio"/> Shortness of breath<input type="radio"/> Wheezing <p>NEUROLOGICAL</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Dizziness<input type="radio"/> Fainting<input type="radio"/> Seizures<input type="radio"/> Numbness<input type="radio"/> Tingling<input type="radio"/> Insomnia <p>PSYCHIATRIC</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Depression<input type="radio"/> Anxiety<input type="radio"/> High stress level<input type="radio"/> Memory loss	<p>HEAD</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Headache<input type="radio"/> Ringing in ears<input type="radio"/> Mouth sores<input type="radio"/> Sore throat<input type="radio"/> Dry mouth<input type="radio"/> Hoarseness<input type="radio"/> Sinus pain <p>EYES</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Double vision<input type="radio"/> Loss of vision<input type="radio"/> Red, itchy eyes <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Chest pain<input type="radio"/> Chest tightness<input type="radio"/> Palpitations<input type="radio"/> Difficulty breathing lying down<input type="radio"/> Exercise intolerance <p>HEMATOLOGIC</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Easy bruising<input type="radio"/> Prolonged bleeding<input type="radio"/> Coughing up blood<input type="radio"/> Vomiting blood<input type="radio"/> Blood in stool<input type="radio"/> Blood in urine <p>NECK</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Lumps<input type="radio"/> Swollen lymph nodes<input type="radio"/> Pain<input type="radio"/> Stiffness	<p>MUSCULOSKELETAL</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Muscle pain<input type="radio"/> Joint pain<input type="radio"/> Stiffness<input type="radio"/> Back pain<input type="radio"/> Swelling <p>ENDOCRINE</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Excessive thirst<input type="radio"/> Frequent urination<input type="radio"/> Heat intolerance<input type="radio"/> Cold intolerance<input type="radio"/> Increase in appetite<input type="radio"/> Decrease in appetite<input type="radio"/> Hair loss <p>GENITOURINARY</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Burning while urinating<input type="radio"/> Painful urination<input type="radio"/> Urinary urgency<input type="radio"/> Flank pain <p>GASTROINTESTINAL</p> <ul style="list-style-type: none"><input type="radio"/> None<input type="radio"/> Nausea<input type="radio"/> Vomiting<input type="radio"/> Diarrhea<input type="radio"/> Constipation<input type="radio"/> Bloating<input type="radio"/> Swallowing difficulties<input type="radio"/> Heartburn
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LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

I, _____, acknowledge receiving on
(print patient name)

_____, a copy of Loudoun Medical Group's Notice of Privacy Practices.
(print date)

Patient signature or initials

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) Other:



Patient Name: _____ DOB: _____

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients’ wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents

X_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out

X_____ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

Date

Relationship (if any)

LOUDOUN MEDICAL GROUP / INFECTIOUS DISEASE TROPICAL MEDICINE
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

As required by the privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

ADDITIONAL CONTACT INFORMATION

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following person(s), entity(s), or business associates of this office:

<u>Name</u>	<u>Phone</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give Dr. Sarfraz Choudhary office permission to leave my results or any pertinent medical information on my home voicemail or my cell phone. Please circle: YES or NO

My signature verifies that this request accurately reflects my wishes. I understand that this form is **valid for 1 year from date of signature**. It is my responsibility to notify Infectious Disease of any changes prior to the expiration of this form.

Signature

Date

I understand that I have the right to: Revoke this authorization at any time by giving written notice to the office. Inspect a copy of patient health information being used for disclosure under federal law. Refuse to sign this authorization. Receive a copy of this authorization and restrict what is disclosed with this authorization.

REFUSAL TO SIGN ONLY

I understand that if I do not sign this document it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Refusal to Sign Signature: _____ Date: _____

Witness Signature: _____ Date: _____