CENTREVILLE OB/GYN
14701 LEE HWY, SUITE 304
CENTREVILLE, VA 20121
703-830-4388|703-830-4188 (f)

RCM Doctors & Midwives

RESTON WOMEN'S CENTER
1850 TOWN CENTER PKWY,
SUITE 650, PAVILION II,
RESTON, VA 20190
703-955-5978| 571-267-7903(f)

PATIENT INFORMATION

Name (Last) _____ (First) _____ (M.I.) _____

Preferred Name: _____ Age: _____

Date of Birth _____Social Security #_____

Address_____City_____

State _____ Zip _____ Home Phone _____

Cell Phone_____ Work Phone_____Race _____

Ethnicity _____ Preferred Language_____

Email to sign up for Patient Portal_____
Appointment reminders: Do you prefer **[ ] Phone call [ ] Text Message [ ] none**

Insurance Information

Who is the insured? [ ] Self [ ] Spouse [ ] Other: _____

If you are **NOT** the policy holder, please complete the following:

Name (of the insured):_____

DOB (of the insured):_____

Subscriber ID:_____ Group Number:_____

Address (of the insured, if different from yours):_____
If insurance is Tricare please provide the policy holder's Social Security#:_____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Phone # _____
Address _____
City/State/Zip_____

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For medical staff use: Height:_____ Weight:_____ B/P:_____HR:_____

Patient Name: _____ DOB: _____

Reason for your visit: _____

Current Medication *including vitamins and minerals*

Drug Name	Dose	Drug Name	Dose

General Medical History

Please circle any conditions you have or have had before:

Alcoholism
Anemia
Anxiety
Arthritis
Asthma
Blood Transfusion
Broken Bones
Cancer
Chickenpox
CVA
Depression
Diabetes
Eating Disorder
Epilepsy
Gallbladder Disease
Gastric Ulcer
GERD
Gestational Diabetes
Glaucoma
Headache
Heart Attack
Heart Murmur
Hepatitis
High Cholesterol
High Risk Pregnancies
HIV or AIDS
Hypertension
Hypothyroidism
Kidney Infections
Kidney Stone
Migraine
MTHFR
Obesity
Pneumonia
Pulmonary Disease
Reflux
Rheumatic Fever
Rheumatoid Arthritis
Stroke
Thyroid Disease
TIA
Tuberculosis
Urinary Tract Infections
STD's
Other:_____

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ALLERGIES

List Drug, Environmental, and Food allergies	Reaction

SURGICAL HISTORY

Surgery	Month/Year	Surgery	Month/Year

HOSPITALIZATIONS

Reason	Month/Year	Reason	Month/Year

FAMILY HISTORY

List maternal or paternal relationship to patient (mother, father,sister,brother, etc.)

__ No family History
__ Patient is adopted
__ Unknown Maternal History
__ Unknown Paternal History
__ Alcoholism _____
__ Anemia _____
__ Asthma _____
__ Birth Defects _____
__ CAD _____
__ Cardiovascular Disease _____
__ Cancer _____
__ Congenital Anomaly _____
__ COPD _____
__ Crohn's Disease _____
__ CVA/TIA _____
__ Depression _____
__ Diabetes _____
__ Epilepsy _____
__ GERD _____
__ High Blood Pressure _____
__ High Cholesterol_____
__ Hypothyroidism _____
__ Kidney Disease _____
__ Liver Disease _____
__ Multiple Births _____
__ OA _____
__ Osteoporosis _____
__ Pulmonary Disease _____
__ Other _____

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Social History

Do you Smoke? _____ How many a day? _____
Have you ever smoked?_____ Quit Date:_____
Do you drink Alcohol? _____ How often? _____
Any Caffeine Use? _____ How often? _____
Any Recreational Drug Use (If so what kind)? _____
Are you a victim or have been a victim of sexual assault/rape? **( ) yes ( )no**
Do you wear a seatbelt? **( ) yes ( ) no** Do you exercise **( ) yes ( )no**

GYN History

Age of first Period? _____What is the first day of your last menstrual period? _____
How many days apart are your menstrual cycles? _____ How long did it last? _____
Pain with periods? _____ Recent changes in period? _____
Are you currently sexually active? ☐ Yes ☐ No ☐ Never With? ☐ Men ☐ Women ☐ Both
Are you currently using birth control? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No
Current birth control: _____ Are you satisfied with it? ☐ Yes ☐ No
When was your last PAP Smear? _____ Results:
_____
Have you ever had an abnormal PAP? ☐ Yes ☐ No If so, when? _____
What was the abnormality? _____
Have you ever had the following?
☐ Colposcopy - Date:___/___/___ ☐Cryosurgery - Date: ___/___/___ ☐LEEP - Date: ___/___/___
Do you do self-breast exams monthly? ☐ Yes ☐ No
Have you had a mammogram? ☐ Yes ☐ No If so when? _____ Result: _____
Have you had a Bone Density Test? ☐ Yes ☐ No If so when: _____ Result: _____
Request to be tested for STD's, including HIV? ___ yes ___no

****By law all positive results should be reported to the Department of Health of Virginia****

Obstetric History

How many pregnancies? _____ Full-Term:_____ Pre-Term:_____
Abortion(s):_____Miscarriages:_____ Live Children: _____C-Sections: _____
Vaginal Deliveries: _____ Forceps or Vacuums:_____

Pregnancy #1- Date_____, M/F_____, weight_____, gestational age_____, medicated(epidural)_____, c/s or vaginal:_____Problems during pregnancy _____

Pregnancy#2- Date_____, M/F_____, weight_____, gestational age_____,

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medicated(epidural)_____, c/s or vaginal:_____Problems during pregnancy_____

Pregnancy #3- Date_____, M/F_____, weight_____, gestational age_____, medicated(epidural)_____, c/s or vaginal:_____Problems during pregnancy_____

Review of Symptoms

****please check if any of the following apply to you currently****

☐ **Unexplained Weight change: ___gain ___loss**	☐ **Involuntary urine loss**
☐ **Fever**	☐ **Painful and/ frequent urination**
☐ **Dizzy Spells**	☐ **Feeling of incomplete bladder empty**
☐ **Trouble with eyes**	☐ **Blood in urine**
☐ **Nosebleeds**	☐ **Trouble with balance**
☐ **Trouble with nose/sinuses**	☐ **Severe joint or muscle pain**
☐ **Chest Pain**	☐ **Changes in skin lesions (warts, moles)**
☐ **Irregular and/or rapid heart beat**	☐ **Breast pain**
☐ **Coughing up a lot of phlegm or mucus**	☐ **Nipple discharge**
☐ **Coughing spells**	☐ **Migraine headaches**
☐ **Trouble breathing**	☐ **Awaken with headaches**
☐ **Nausea**	☐ **Trouble sleeping**
☐ **Vomiting**	☐ **Hot Flashes**
☐ **Constipation**	☐ **Night Sweats**
☐ **Feeling of incomplete emptying of stools after bowel movement**	☐ **Difficulty Concentrating**
	☐ **Hair loss or thinning**
☐ **Involuntary loss of gas or stool**	☐ **Increased body or facial hair**
☐ **Diarrhea**	☐ **Decreased sex drive**
☐ **Blood in stool**	☐ **Difficulty achieving orgasm**
☐ **Heartburn/Indigestion**	☐ **Loose feeling of the vagina with or without decreased feeling during sex**
☐ **Pain with Intercourse**	☐ **Partner complaining of the above**
☐ **Bleeding with Intercourse**	☐ **Sensation of something bulging or falling from vagina**
☐ **Abnormal vaginal discharge**	☐ **Labia (vulvar lips) too long or excessive**
☐ **Vaginal odor, itching, dryness**	☐ **Unusual fatigue**
☐ **Irregular periods, heavy periods**	☐ **Heat or cold tolerance**
☐ **Pain or severe cramping with periods**	☐ **Frequent bruising**
☐ **Severe premenstrual symptoms**	
☐ **Bloating and/or excess gas**	
☐ **Pelvic and/ or abdominal pain**	

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I, hereby authorize Centreville OB/GYN and /or their representatives to release any and all information pertaining to my health care, including test results, procedure, billing and/ or accounting information to the following person (s) or agencies.

- Myself
- Parents
- Insurance
- No one
- Other (Please specify) _____

I further authorize the physicians and their representatives to release the results of my medical exams in one or more of the following ways:
(please check all that apply)

- May call me
- a May NOT call me
- Mail
- At work
- At home
- Email _____

May leave message to return call to physician's office:

- At home
- At work
- Voicemail
- None

I understand that this office will NOT release any information to those persons who I have not listed without a separate consent. I also understand that this relates to all medical as well as account information. If I wish to make changes to the status of this form, I will do so in writing.

Patient's Signature _____ Date _____

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NOTICE OF DEEMED CONSENT OF BLOOD TESTING

A new Virginia law was enacted in 1989 that allows health care providers to test their patients for HIV antibodies when a health care worker is exposed to the blood or body fluids of a patient in a way which may transmit human immunodeficiency virus (HIV), the virus which causes AIDS. Because of this law, in the event of such exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the exposed health worker. Except in emergencies, you **will** be informed before any of your blood is tested for HIV antibodies, the testing will be explained to you and you will be given the opportunity to ask any questions you might have. You will be provided with the test results and appropriate counseling. Test results, if positive are required by law to be reported to the Virginia Department of Health. I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing."

Patient Signature: _____ Date: _____

Patient Name: _____

PRIVACY PRACTICES ACKNOLEDGMENT FORM

I have been provided an opportunity to review the Notice of Privacy Practice.
Name: _____ Date of Birth: ____/____/____
Signature: _____ Date: ____/____/____

Insurance Acknowledgment Form

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 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.
Signature: _____ Date: _____

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For Annual/Well-Woman Exam:

An Annual gynecological exam, known as "preventative management (PM)" for insurance purposes consist of a physical exam (vital signs and examination of the neck, breast, abdomen, pelvic and possibly rectum), collection of a pap smear, and certain age appropriate counseling and testing. Additional test preformed during this visit include Gonorrhea and Chlamydia screening for women under 25 years old, or with multiple sex partners. If the pap smear is mildly abnormal, an HPV test will be added to the pap smear to determine further follow-up. For women over 30 an HPV screening is performed during the visit. HPV is a sexually transmitted disease (STD). Gonorrhea and Chlamydia are also STD's ad these infections must be reported to the VA State Board of Health, which may contact you to inform your partner(s) regarding possible infection. Routine blood work is also drawn during this visit (example : cholesterol, TSH, CBC, etc.)

For women over 40 years old, recommended additional testing includes a yearly mammogram and yearly screening for colon cancer. Mammograms are generally covered by insurance ; colon cancer screening or blood work may not be.

For Consultations/Problems:

Consultations regarding current gynecological problems are generally covered, unless your insurance considers the condition "preexisting" to your current insurance coverage. Consultations for certain health maintenance (example: exercise, diet and weight loss), mental status (example: depression, anxiety and sexual dysfunction) may not be covered. It is your responsibility to know the details of what your insurance policy covers.

If you have any questions, please feel free to ask a staff member.

I have read and understand the components and limitations of preventative management as stated above. I am aware that some insurance plans do not cover (pay for) "preventative" or "routine" medical visits, or visits for "preexisting" conditions, in which case I will be responsible for payment to the office and laboratory for services rendered.

Print Name: _____ Date of Birth: _____/_____/_____

Signature: _____ Date:_____/_____/_____

Witness: _____ Date: _____/_____/_____

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Patient Responsibilities and Office Policies

Please read and initial acknowledgment of each office policy below.

_____ Notify us of any changes to your address or insurance information at the time of the change.

_____ All appointments must be scheduled in advance. If you are more than 15 minutes late for an appointment, you will be asked to reschedule.

_____ There is a fee for copying medical records. There is a $10.00 processing fee, plus $0.50 per page, a maximum of $25.00. Records may take up to 14 days to process, so make sure your release form is submitted in the appropriate time frame. (This is only if you are transferring care to another physician).

_____ There is a $35.00 fee for all returned checks.

_____ Please be advised that we will notify you by mail of **ALL** test results. Test results that require additional testing or that is abnormal will require a consultation appointment to discuss the results.

_____ A $10.00 fee is required for all types of disability forms. This fee is also required for letters needed with medical details (i.e. visa letters, denied laboratory services, etc.)

_____ A $50.00 charge will be billed to you for failing to keep your appointment and not providing at least 24 hours. A $250.00 charge will be billed to you for failing to provide at least 72-hour cancellation of surgery.

_____ Co-payments will be collected at the time of your visit. If you do not have your payment at the time of service, then your visit will be rescheduled. We will not bill you for your co-payment.

_____ Self-Pay Patients: All fees for service rendered will be paid in full at the time of your visit. We will not balance bill.

_____ The physician's billing representative will file your office visits. Surgeries and obstetrical care to your insurance. We will complete all requirements to get your claims paid in a timely fashion. However, all claims not paid by your insurance, **WILL** become your responsibility.

_____ It is also your responsibility to check with your insurance company to verify that we are a participating provider of your health plan prior to services. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (This includes all lab and radiology tests). Your office visit does not include the cost of lab or additional procedures (i.e. ultrasound).

_____ Know your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your benefits are, and if referrals are required. If you come without getting proper referrals or if your insurance denies your visit stating that it is a non-covered service, you understand that this means you become responsible for this service.

_____ If you do not have a valid insurance card (enrollment information will not be acceptable), you will be required to pay in full at the time of service. You will then be responsible for filing a claim with your insurance company for reimbursement. Of you will have to reschedule your appointment.

_____ A $15.00 fee is required for **ALL** lost prescriptions and referral forms (i.e. Radiology orders and orders for other doctors).

I, _____ have read, understand, and accept the above policies.

_____ _____

Signature Date

Thank you in advance for your cooperation and understanding.