Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian | Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Women Only:

of Pregnancies _____ # of Miscarraiges _____ # of Abortions _____ # of Living _____

Last Pap Smear _____ Last Mammogram _____ Birth Control Method _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

OneHealth Medical
All about people, all about your health.

Financial and Insurance & Patient Billing Policies

Thank you for choosing us for your healthcare needs. Our goal is to provide and maintain an excellent physician-patient relationship. The following is our Financial Policy, which we ask you to review carefully and sign prior to your visit.

General Information

Your co-payment, deductible, co-insurance, or payment in full is due at the time of service. We accept cash, Visa, MasterCard, Discover, and American Express. **Initial:** _____

Self-Pay Patients

Patients without health insurance are expected to pay at the time of service. **Initial:** _____

Missed Appointments

Unless cancelled at least 24 hours in advance, your appointment could be considered a no-show. Our policy allows us to charge you up to $25 for this type of missed appointments. Please help us serve you better by keeping your scheduled appointments. **Initial:** _____

Regarding Insurance

One Health Medical Care (OHMC) providers participate in a wide variety of managed care plans. We are happy to bill health insurance carrier as a courtesy to you. We suggest that all patients review their health coverage with their carrier prior to receiving services or treatment. It is the responsibility of the patient to notify us of any changes in the insurance policy. Your insurance policy is a contract between you and your insurance company, and the OHMC staff will not know the terms of your insurance policy. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under your medical insurance. The patient/financial guardian will be responsible for any remaining balances. Additionally, it is your responsibility to obtain and track referrals for your visits. **Initial:** _____

Patient Accounts

For patients with insurance: After medical claim for your visit is submitted to and processed by your insurance company, you will be responsible for any remaining balance indicated by your insurance plan as "Patient Responsibility". Patient account or billing statement will be sent to you by email and/or by mail to your last known address. Courtesy notification of outstanding bills may also be sent through voicemail/text/SMS to your mobile number. It is your responsibility to notify us of any change in your contact information. You agree to make the payment of the remaining balance in 14 days after you receive the statement. We reserve the right to charge service or interest charges for unpaid or overdue bills as permitted by law. Delinquent accounts will be turned over to collection, and you agree that you will be responsible for the attorney and collection fees. **Initial:** _____

By signing below, I acknowledge that I have read, understand, and agree to this Financial Policy.

Patient Name _____ Date _____

Patient/Responsible Party Members' Signature _____

Reponsible Party Member's Name _____ Relationship _____

(12/2016)

Individuals may complain to OHMC and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. OHMC's contact person for matters relating to complaints is:

Mingliarti Tjahjana, MD – One Health Medical Care (OHMC) Privacy Official
1850 Town Center Dr, Suite 410, Reston, VA 20190
Ph: 571.572.9198

Please provide the name(s) of person(s) if any, to whom you would permit One Health Medical Care (OHMC) to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to this Privacy Policy.

List Below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from OHMC as necessary during the course of your health care services:

Name and Relation (circle one)	**Allowed Disclosure(s) - Please circle ALL or specify**
Spouse:_____	All or Specify:_____
Family/Friend-Name: _____	All or Specify:_____
Family/Friend-Name: _____	All or Specify:_____
Family/Friend-Name: _____	All or Specify:_____
Family/Friend-Name: _____	All or Specify:_____

By signing below, you will allow interpreter services if necessary for communication with health care providers

By signing below, you acknowledge and understand that One Health Medical Care' policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. OHMC's policy is to only disclose specific information necessary for coordination of your health care or medical treatment.

By signing below, you acknowledge, understand, and accept One Health Medical Care' policy to contact you by various means when necessary for your health care services, including sending you account or billing statements, that may include your home/work/cell phone, fax, and/or email. You also understand that private health information may be included in that communication to you. Please list below methods of communication you DO NOT want OHMC to use:
_____

I hereby acknowledge that I have read One Health Medical Care Notice of Privacy Practices and received a copy (if requested).

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____