NEW PATIENT REGISTRATION FORM

Patient Profile

Last Name

Gender: Male ☐ Female ☐

Marital Status: S M D W

First Name   Middle Initial

Date of Birth of Patient (MM/DD/YYYY)

Mailing Address (Street Number and Name)   Apt #

SSN of Patient

(City)   (State)   (Zip Code)

Employer of Patient   Occupation

Language: ________________________

Ethnicity: Hispanic/Latino   Not Hispanic or Latino

Race: Asian   Asian Indian   Black or African American   Middle Eastern or North African   White

Home phone: ____

Cell Phone:____

Email Address: ______________________________________

How did you hear about us?

___ Advertising   ___Primary Care Physician   ___Word of Mouth
___ Hospital   ___Specialist Physician   ___Insurance Company
___ Zocdoc   ___Patient in Practice   ___Beacon
___Other___________________

Emergency Contacts

Full Name	**Relationship to Patient**	**Contact Phone Number**
________________________	_________________________	_________________________________
________________________	_________________________	_________________________________

I authorize SCMC to release information pertaining to my condition/care to those individual(s) below:

Full Name	**Relationship to Patient**	**Contact Phone Number**
________________________	_________________________	_________________________________
________________________	_________________________	_________________________________

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copay deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **I understand that if I do not cancel my appointment within 24 hours, I am responsible for a $20.00 no show fee.**
- **I herewith attest that the information provided by me on this form, is accurate**

X   **Signature:** ____ **Date**_________________________________

Advance Directive Notification

An Advance Directive is a document that states what medical procedures you want performed in the event you have a serious illness or accident and are unable to speak for yourself. You can use this in two ways, you can appoint a relative or friend to make medical decisions for you, or you can specify which medical procedures you do or do not want performed. Physicians are required to follow your instructions or transfer your care to a physician that will. An Advance Directive helps ensure that your wishes are followed.

I have executed an Advance Directive   ___Yes   ___NO
(If you have answered "Yes", **please provide a copy for your medical record**)

I would like to discuss this Advance Directive   ___Yes   ___NO

X   **Signature:** ____ **Date:** ___________________________

Seven Corners Medical Center

6045 Arlington Blvd, Falls Church, VA 22044 Phone (703)237-7900 FAX (703)237-0821

Name:	Date of Birth:	Age:	Sex:

MEDICAL HISTORY - Include approximate date of diagnosis

	Yes	No		Yes	No		Yes	No
Abdominal Aortic Aneurysm			OTHER:			Skin Disorder / Rash		
Anemia			Epilepsy / Seizures			Sleep Apnea		
Anxiety			GERD/Reflux			Stroke TIA		
Arthritis			Hair Loss			Thyroid Problem		
Asthma			Heart Attack/Angina			Tuberculosis		
Blood Clot			High blood Pressure / Hypertension			Weight Gain/Loss		
COPD			High Cholesterol / Hyperlipidemia			**MALES ONLY**		
Cancer			HIV			Erectile Dysfunction		
Cardiomyopathy/heart disease			Insomnia			Prostate Problem		
Congestive Heart Failure			Kidney Disease					
Constipation			Liver Disease			**FEMALES ONLY**		
Coronary Artery Disease			Neurological Disorder			Currently Pregnant		
Depression			Osteoporosis			Child Bearing Potential?		
Diabetes Mellitus			Rectal Bleeding			Number of Pregnancies?		
OTHER:			Sexually Transmitted Diseases			Date of Last Pap Smear		
OTHER:			Specify:			Date of Last Mammogram		

LIST SURGERIES and DATES:	**ALLERGIES/REACTION: (medication, food, environmental)**

FAMILY HISTORY: Significant Medical History	If Deceased, Cause of Death and Age
Father	
Mother	
Brother(s)	
Sister(s)	

Patient Lives with:	Contraception (circle) YES NO METHOD:
Sexual Orientation: (circle) Heterosexual Homosexual Other: ___________________________	Nutrition (circle) POOR GOOD
	Exercise (circle) YES NO FREQUENCY/DURATION: _______________

Social History: (please circle):

Smoking Status	Non-smoker	Former-smoker	Current –Smoker	________per/day	______years of use
Alcohol intake	None	Occasionally	Moderate	Heavy	______drinks/week
Caffeine Intake	None	Occasionally	Moderate	Heavy	______times/week
Recreational Drug Use	None	Type:	Frequency:		

PREFERRED PHARMACY:

Patient Name: ______________________________________ Date of Birth: _________________________

POLICIES AND PAYMENTS

All Professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. Your insurance policy is a contract between your insurance and you. We cannot accept responsibility for negotiating settlement of insurance claims. You are responsible for prompt payments of any bills due to us, from this service provided to you.

PREVENTATIVE VISITS / ANNUAL PHYSICAL EXAM

At a PREVENTATIVE VISIT, your doctor will likely assess your health risks by talking with you about

- Your current health
- Your family health history
- Past illnesses and surgeries
- Risks you may have for specific conditions
- How to maintain a healthy lifestyle

Your doctor will also likely

- Check your weight, height, temperature, blood pressure and pulse
- Listen to your heart and lungs
- Check your ears, eyes, throat, skin and abdomen
- Recommend preventative vaccines, screenings or tests you may need

OFFICE VISITS

At an OFFICE VISIT, your doctor will treat or discuss a specific health concern, illness or condition. This visit is typically subject to a copay, deductible or coinsurance.

PLEASE BE ADVISED, IF YOU ARE SCHEDULED FOR A PHSYICAL EXAM AND YOU HAVE HEALTH CONCERNS ABOUT A NEW OR EXISTING CONDITION OR AN ILLNESS AND YOUR PHYSICIAN HAS TIME TO ADDRESS THE HEALTH CONCERNS AT THE SAME TIME AS YOUR SCHEDULED PHYSICAL EXAM, YOUR PHYSICIAN CAN PERFORM THE TWO VISITS; HOWEVER, PLEASE BE REMINDED, THE OFFICE VISIT PORTION IS SUBJECT TO YOUR COPAY, DEDUCTIBLE AND/OR COINSURNACE AND IS DUE AT THE TIME SERVICES ARE RENDERED.

Insurance Authorization and Assignment

I hereby authorize Seven Corners Medical Center to furnish information to the insurance carriers concerning my illness and treatments and I hereby assign to the physician (s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by the insurance.

Consent to Release Personal Health Information (PHI)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent and prior to any service being provided to you by the practice. The Practice reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPPA Officer or by asking the provider's receptionist. You can also obtain a copy on the clinic's website at www.sevencornersmedical.com

By signing this form, you acknowledge that you have been given the opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by this practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPPA) and Heath Information Technology for Economic and Clinical Health Act (HITECH).

By signing below, I hereby acknowledge and understand the payment polices, and consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described.

X **Signature of Patient/Legal Representative:________________________________ Date: __________**

If Legal Representative, relationship to Patient: ______________________________