LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

INFECTIOUS DISEASE TROPICAL MEDICINE & TRAVEL CLINIC

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 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)* White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/ Alaska Native	**ETHNICITY** *(please circle one)* Hispanic or Latino Not Hispanic or Latino Unknown	**PREFERRED LANGUAGE** English Spanish Or 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 Work. 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 PHYSCIAN (pcp) &/or REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. 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 ever **TRAVELLED OUTSIDE THE COUNTRY**? ◯ 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 **TB TEST** or **HISTORY OF EXPOPSURE**? ◯ Yes ◯ No
If yes, please explain: _____

Have you ever had any **BITES** or **RASHES**? ◯ Yes ◯ No
If yes, please explain: _____
Did it require treatment by physician: ◯ Yes ◯ No

SURGERIES: Have you ever had surgery (ies)? ◯ Yes ◯ No
If yes, please state type of **surgery** (ies) and **when** below:

Type of Surgery	Date of Surgery (approximate)

Have you ever been **HOSPITALIZED**? ◯ Yes ◯ No
If yes, please state cause and when? _____

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	Ear Infections	High Cholesterol	Other:
Chronic Sinusitis	Renal Disease	HIV or AIDS	Other:

FAMILY HISTORY

Father		◯ Alive ◯ Deceased	◯ Healthy ◯ Medical Problems:
Mother		◯ Alive ◯ Deceased	◯ Healthy ◯ Medical Problems:
Brother (s)	#	◯ Alive ◯ Deceased	◯ Healthy ◯ Medical Problems:
Sister (s)	#	◯ Alive ◯ Deceased	◯ Healthy ◯ Medical Problems:
Son (s)	#	◯ Alive ◯ Deceased	◯ Healthy ◯ Medical Problems:
Daughter (s)	#	◯ Alive ◯ Deceased	◯ Healthy ◯ 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 ◯ Transgender

Name: _____ Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Please indicate if you have any of the symptoms below:

GENERAL
- ◯ None
- ◯ Fever
- ◯ Chills
- ◯ Fatigue
- ◯ Weakness
- ◯ Night sweats
- ◯ Difficulty walking

SKIN
- ◯ None
- ◯ Rash
- ◯ Itching
- ◯ Lumps

RESPIRATORY
- ◯ None
- ◯ Cough
- ◯ Sputum production
- ◯ Coughing up blood
- ◯ Shortness of breath
- ◯ Wheezing

NEUROLOGICAL
- ◯ None
- ◯ Dizziness
- ◯ Fainting
- ◯ Seizures
- ◯ Numbness
- ◯ Tingling
- ◯ Insomnia

PSYCHIATRIC
- ◯ None
- ◯ Depression
- ◯ Anxiety
- ◯ High stress level
- ◯ Memory loss

HEAD
- ◯ None
- ◯ Headache
- ◯ Ringing in ears
- ◯ Mouth sores
- ◯ Sore throat
- ◯ Dry mouth
- ◯ Hoarseness
- ◯ Sinus pain

EYES
- ◯ None
- ◯ Double vision
- ◯ Loss of vision
- ◯ Red, itchy eyes

CARDIOVASCULAR
- ◯ None
- ◯ Chest pain
- ◯ Chest tightness
- ◯ Palpitations
- ◯ Difficulty breathing lying down
- ◯ Exercise intolerance

HEMATOLOGIC
- ◯ None
- ◯ Easy bruising
- ◯ Prolonged bleeding
- ◯ Coughing up blood
- ◯ Vomiting blood
- ◯ Blood in stool
- ◯ Blood in urine

NECK
- ◯ None
- ◯ Lumps
- ◯ Swollen lymph nodes
- ◯ Pain
- ◯ Stiffness

MUSCULOSKELETAL
- ◯ None
- ◯ Muscle pain
- ◯ Joint pain
- ◯ Stiffness
- ◯ Back pain
- ◯ Swelling

ENDOCRINE
- ◯ None
- ◯ Excessive thirst
- ◯ Frequent urination
- ◯ Heat intolerance
- ◯ Cold intolerance
- ◯ Increase in appetite
- ◯ Decrease in appetite
- ◯ Hair loss

GENITOURINARY
- ◯ None
- ◯ Burning while urinating
- ◯ Painful urination
- ◯ Urinary urgency
- ◯ Flank pain

GASTROINTESTINAL
- ◯ None
- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Constipation
- ◯ Bloating
- ◯ Swallowing difficulties
- ◯ Heartburn

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:**

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:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

REFUSUAL 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: _____