RESTON WOMEN'S CENTER

1850 TOWN CENTER DRIVE

PAVILION II, SUITE 650

RESTON, VA 20190

PATIENT INFORMATION

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

Date of Birth _____ Social Security Number _____

Address _____ City _____

State _____ Zip _____ (M/F) _____ Marital Status _____

Home Phone _____ Cell Phone_____ Work Phone_____

Emergency Contact _____ Phone Number _____

Race _____ Ethnicity _____ Preferred Language_____

Email to sign up for Patient Portal _____

Appointment reminders: Do you prefer [ ] Phone call [ ] Text Message [ ] none

PRIMARY INSURANCE

Insurance Name _____ Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Subscriber _____

**If insurance is Tricare please provide the policy holder's Social Security Number _____

Subscriber ID # _____ Group # _____

SECONDARY INSURANCE

Insurance Name _____ Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Subscriber _____

**If insurance is Tricare please provide the policy holder's Social Security Number _____

Subscriber ID # _____ Group # _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Phone Number _____

Address _____ City/State/Zip_____

PRIMARY CARE PHYSICIAN

Physician Name/Practice Name _____Phone Number_____

Address _____ City/State/Zip _____

PATIENT AUTHORIZATION

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 payer, 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.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Print Name _____ Relationship to Patient _____

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Patient Name _____ DOB _____ Date _____

Current Medication

Drug Name	Dose	Drug Name	Dose

Personal Medical History

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

Allergies

List drug, environmental and food allergies	Reaction

Surgical History

Surgery	Month/Year	Surgery	Month/Year

Hospitalizations

Hospitalization Reason	Month/Year	Hospitalization Reason	Month/Year

Family History

****please specify what family member and if they are maternal or paternal****

Condition	Family Member	Condition	Family Member	Condition	Family Member
No Family History		CDA		High Cholesterol	
Patient is adopted		Congenital Anomaly		Hypothyroidism	
Unknown Maternal History		COPD		Kidney Disease	
Unknown Paternal History		Crohn's Disease		Multiple Births	
Alcoholism		CVA/TIA		OA	
Anemia		Depression		Osteoporosis	
Asthma		Diabetes		Pulmonary Disease	
Birth Defect		Epilepsy		Other	
Cancer		GERD			
Cardiovascular Disease		High Blood Pressure			

Social History

Smoking: ☐ Yes ☐ No Pack/day: _____ Years: _____ Quit Date: _____
Alcohol: ☐ Yes ☐ No Drinks/day: _____ Years: _____ Quit Date: _____
Drug Use: ☐ Yes ☐ No Type:_____ Years: _____ Quit Date: _____
Caffeine: ☐ Yes ☐ No Cups/day: _____ Week:_____
Do you wear a seatbelts? ☐ Yes ☐ No Are you a victim of sexual assault/rape? ☐ Yes ☐ No
Do you Exercise? ☐ Yes ☐ No Do you take calcium supplements? ☐ 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 a 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: _____

Pregnancy History

Total Times Pregnant		Living Children		Miscarriages	
Full term deliveries		Vaginal Delivery		Abortions	
Pre term Deliveries		Cesarean sections		Forceps or Vacuums	
Pregnancy # 1	Birth Year: _____, Gender: _____, Birth Weight: _____, Gestation: _____, Anesthesia(epidural): _____, Vaginal or C-section: _____, Problems (during pregnancy) _____				
Pregnancy # 2	Birth Year: _____, Gender: _____, Birth Weight: _____, Gestation: _____, Anesthesia(epidural): _____, Vaginal or C-section: _____, Problems (during pregnancy) _____				
Pregnancy # 3	Birth Year: _____, Gender: _____, Birth Weight: _____, Gestation: _____, Anesthesia(epidural): _____, Vaginal or C-section: _____, Problems (during pregnancy) _____				
Pregnancy # 4	Birth Year: _____, Gender: _____, Birth Weight: _____, Gestation: _____, Anesthesia(epidural): _____, Vaginal or C-section: _____, Problems (during pregnancy) _____				

Review of Systems

please check if any of the following apply to you now

☐ 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	
☐ Bleeding with Intercourse	☐ Partner complaining of the above
☐ Abnormal vaginal discharge	☐ Sensation of something bulging or falling from vagina
☐ Vaginal odor, itching, dryness	
☐ Irregular periods, heavy periods	☐ Labia (vulvar lips) too long or excessive
☐ Pain or severe cramping with periods	☐ Unusual fatigue
☐ Severe premenstrual symptoms	☐ Heat or cold tolerance
☐ Bloating and/or excess gas	☐ Frequent bruising
☐ Pelvic and/ or abdominal pain	

Please Choose Yes or No. If Yes, please explain

New Hospitalizations or surgeries? ☐ Yes ☐ No

Any new family medical problem? ☐ Yes ☐ No

Request to be tested for STD's? ☐ Yes ☐ No

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

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Patient Responsibilities and Office Policies

Please read and initial acknowledgement of each 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 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 are abnormal will require a consultation appointment to discuss 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 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 the appointment.

_____ 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 test your insurance policy covers and does not cover. (this includes all lab ad 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 ad regulation. 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 filling a claim with your insurance company for reimbursement. Or you will have to reschedule your appointment.

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

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

_____ _____

Signature Date