

# 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 \_\_\_\_\_

## PATIENT INFORMATION

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 # \_\_\_\_\_

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## 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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Date: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Reston Women's Center 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
- May NOT call me
- Mail
- At work
- At home

May leave messages to return call to the 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 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 (printed) Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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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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## **PRIVACY PRACTICES ACKNOWLEDGMENT FORM**

I have been provided an opportunity to review the Notice of Privacy Practice.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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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 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 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: \_\_\_\_\_

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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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pack/day: _____ Years: _____	Quit Date: _____
Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No	Drinks/day: _____ Years: _____	Quit Date: _____
Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ Years: _____	Quit Date: _____
Caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cups/day: _____ Week: _____	
Do you wear seatbelts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a victim of sexual assault/rape? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you Exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take calcium supplements? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	With? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
Are you currently using birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	Trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current birth control: _____	Are you satisfied with it? <input type="checkbox"/> Yes <input type="checkbox"/> No
When was your last PAP Smear? _____	Results: _____
Have you ever had an abnormal PAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when? _____
What was the abnormality? _____	
Have you ever had a the following:	
<input type="checkbox"/> Colposcopy - Date: ___/___/___	<input type="checkbox"/> Cryosurgery - Date: ___/___/___
<input type="checkbox"/> LEEP - Date: ___/___/___	
Do you do self-breast exams monthly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so when? _____ Result: _____
Have you had a Bone Density Test? <input type="checkbox"/> Yes <input type="checkbox"/> 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\*\***

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