UROGYNECOLOGY CENTER
NORTHERN VIRGINIA

NEW PATIENT HEALTH HISTORY

Name: ____ Date of Birth: ______________________ Age: _________
Today's Date: _______________ Primary Care Doctor: ___________________ Primary Care Phone: ______________
Referring Doctor: ____________________________ Referring Doctor Phone: _________________________________
Gynecologist: ____________________________________ Gynecologist Phone: _________________________________
Preferred Pharmacy Name: _____________________City: ____________________ Phone: ______________________

CHIEF COMPLAINT

What is the main reason you are seeing the doctor today?

____
____

ALLERGIES: (Please list all medication allergies, including shellfish, etc.)
If no allergies, check here: ☐

____
____

MEDICATIONS: (Please list all medicines including over-the-counter, supplements and vitamins.)
If no medications, check here: ☐

____
____

Date of last Pap smear: ____

SURGERIES:

☐ Tonsillectomy	☐ Wisdom Tooth	☐ Appendectomy	☐ D&C
☐ Gallbladder Surgery	☐ Tubal Ligation	☐ C-Section	☐ Hysterectomy
☐ Shoulder Surgery	☐ Vasectomy	☐ Knee Surgery	☐ Laparoscopy
☐ Hernia Repair	☐ Colonoscopy	☐ Other:	

If no prior surgeries, check here: ☐
Weight: _____________ Height: ______________

FAMILY HISTORY:

	Father	Mother	Brother	Sister	PGF*	PGM*	MGF*	MGM*
Prostate Cancer								
Renal Cancer								
Bladder Cancer								
Testicular Cancer								
Heart Attack								
Heart Disease								
Stroke								
High Blood Pressure								
High Cholesterol								
Diabetes								
Kidney Disease								
Urinary Stones								
Cystic Fibrosis								
Tuberculosis								
Other Cancer Type: ________________								
Other Family Hx.:_________________								

If there is no family history of any of the above, check here: ☐ If family history is not available, unknown or unobtainable, check here: ☐ * PGF – Paternal grandfather (father's father) PGM – Paternal grandmother (father's mother) MGF – Maternal grandfather (mother's father) MGM – Maternal grandmother (mother's mother)

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Personal Information*

Prefix: Mr./Mrs./Other:________Patient Name*:____Suffix: Jr./Sr./Other: _________
Last First Middle Initial

Previous Name: ____________________ Preferred Name: _________________ Email: ____

Mailing Address*: ____
Street Address Apt. # City State Zip

Home #:___________________________Cell #:______________________________Work #:___________________________Ext: _____________

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP):________________________________Address:____________________________Phone #: _________________
First Last

Referring Provider:________________________________Address:__________________________________Phone #: ___________________
First Last

Date of Birth*:_______________Birth Sex*:________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
mm/dd/yyyy

Social Security #:_______-______-________Employer Name:___________________________________Occupation:______________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other:_________________________

Ethnicity*: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino

Gender Identity: ☐ Male ☐ Female ☐ Female-To-Male (FTM)/Transgender Male/Trans Man ☐ Male-To-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose ☐ Other, please specify: ______________

Language*: ☐ English ☐ Spanish ☐ Other: ______________________________________

Sexual Orientation: ☐ Lesbian, gay/homosexual ☐ Straight/heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose

☐ Something else: _________________

Pharmacy Name*:________________________________Address:_______________________________________Phone #:

Emergency Contact*

Name:____Relationship: ____
Last First

Address: ____
Street Address Apt # City State Zip

Home #:___________________________Work #:____________________________Cell #: _________________________

Primary Insurance Information*

Insurance Name:____________________________Member ID #:_________________________Relationship to Insured:___________________
Employer:_______________________________________Group #:____________________________Effective Date: ______________________
mm/dd/yyyy

Insured's Information* - (if not self)

Name:____Date of Birth:_________________Birth Sex:____Social Security #:____-______- ______
Last First mm/dd/yyyy

Relationship to Insured:_________________________________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Address: ____
Street Address Apt # City State Zip

Home #:___________________________Work #:____________________________Cell #: _________________________

Secondary Insurance Information

Insurance Name:____________________________Member ID #:_________________________Relationship to Insured:___________________

Group#:___________________________________Effective Date: ________________________

Secondary Insured's Information - (if not self)

Name:____Date of Birth:_________________Birth Sex: _____Social Security #:____-_____- _______
Last First mm/dd/yyyy

Relationship to Insured:_________________________________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Address: ____
Street Address Apt # City State Zip

Home #:___________________________Work #:____________________________Cell #: _________________________

CONSENT INFORMATION

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. **X_______ (Please initial)**

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:

If any LMG health professional, worker or employee should be directly exposed to your blood or your 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. **X_________(Please initial)**

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 transit 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. **X________(Please initial)**

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents
X_______ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out
X______ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X________(Please initial)**

____ ____________________

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

____

Relationship (if any)

OFFICE POLICIES

Billing

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable co-pay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. If you do not have your insurance information available at the time of your visit, we require that you pay 100% of charges rendered prior to the visit.

If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to over to a collection agency. In addition to the principle balance due, you will also be responsible for any legal or collection agency fees incurred.

Cancellations

We will attempt to contact you to remind you of your appointment 48 hours prior to your appointment. If you are unable to keep your appointment, we require a 24 hours notice of cancellation. If you fail to show for your appointment or cancel without notifying us 24 hours in advance, we reserve the right to charge you a $40.00 no show fee. Fees for procedures/surgery may vary.

If you are 15 minutes late to your appointment, you may be asked to reschedule and you may incur a fee.

Prescription Refills

We request 72 hours to refill prescriptions from time of request. The best way to request refills is to call your pharmacy two (2) weeks before your medication runs out.

Referrals/Prior Authorizations

Please call your insurance to verify if a referral/prior authorization is needed. Some insurance companies do not require a referral. Please allow at least 72 hours to obtain your referral. Some insurance's can take up to 7 business days to receive approval or denial. We cannot back date referrals and we cannot accommodate same day referrals unless it is a true emergency.

Forms/Medical Records

Forms needing to be filled out by a provider (i.e. school physical form, disability paperwork) are subject to a $10-$50 form fee which cannot be billed to your insurance company. Please allow us 72 hours for the forms to be completed. There will be a $10 fee for lost orders/referrals.

After Hours Care

You can reach the on call physician by calling our main office number. The on call physician will advise you where to go based on your medical condition.

Emergencies

If you have a life-threating emergency, please call 911 or go to your nearest emergency room.

By signing this form, I have agreed to the terms and conditions listed above.

______________________________	______________	______________
Printed Patient Name	Date of Birth	Today's Date

____
Patient Signature

______________________________	______________________	______________________________
Printed Name of Personal Representative	Relationship to Patient	Signature of Personal Representative

PERMISSION TO DISCLOSE INFORMATION

I, ____, acknowledge that I was made aware of Urogynecology Center of Northern Virginia/Loudoun Medical Group's Privacy Policy and a copy was made available to me for my review.

I authorize Urogynecology Center of Northern Virginia to disclose my protected health information to the following person(s) and entities:

Name	Date of Birth	Relationship to You

____
Printed Patient Name

____
Today's Date

____
Patient Signature

____
Printed Name of Personal Representative

____
Relationship to Patient

____
Signature of Personal Representative

NOTIFICATION OF TEST RESULTS

In most cases, you will be notified by phone of your test results. Please ensure the phone number we have on file for you is correct.

Preferred phone number: ____

May we leave a detailed message at this number? ☐ Yes ☐ No

UROGYNECOLOGY CENTER
NORTHERN VIRGINIA

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

____
Signature

Date:______________________________

____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative'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:**