Virginia Medical

vma

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PATIENT INFORMATION

Please Print

Last Name: _____

First, M.I.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____

Date of Birth: _____ Sex: M / F

Marital Status: _____ Spouse's Name: _____

E-Mail Address:

_____

Social Security #: _____

E-Mail Address: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Cell Phone: _____

Primary VMA Dr.: _____

Responsible Party (If patient is a minor or employer is responsible)

Last Name: _____

First Name: _____

Relation: _____

Emergency Contact:

Name: _____

Phone: (____) _____

Relation: _____

INSURANCE INFORMATION

PRIMARY POLICY HOLDER

Company Name: _____

Company Address: _____

_____

ID / Certificate #: _____

Group #: _____

Plan #: _____

Policy Holder: _____

SECONDARY POLICY HOLDER

Company Name: _____

Company Address: _____

_____

ID / Certificate #: _____

Group #: _____

Plan #: _____

Policy Holder: _____

I, the undersigned, hereby acknowledge that it is the policy of this office that payment due made at each visit and I am responsible for payment of all services rendered on my behalf. In the event that failure to pay results in referral of my account for collection, I agree to pay collection or attorney fees. If the treating physician is a participant in a HMO, PPO or IPA of which I am a member, I agree to pay any co-payment required by my particular plan. Exception to this policy must be confirmed in advance of service.

Patient's Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to _____ M.D. for any services rendered to me. I authorized any holder of medical information about me to give the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

OTHER INSURANCE PATIENTS:

I authorize payment of medical benefits to the physician or supplier of services rendered.

I authorized release of my medical information necessary to process this claim and also certify that the information obtained herein is correct.

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PATIENT MEDICAL HISTORY

Name:_____ D.O.B.: _____ Age: _____ Sex: _____
Married: _____ Single: _____ Divorced: _____ Separated: _____ Widow: _____
Ethnic Origin: _____ Occupation: _____

Social History

Smoke: ( ) Yes ( ) No **If Yes**: Packs Per Day: _____ Years Smoked: _____
Alcohol Use: _____ Exercise: (Hrs/Wk) _____ Sleep: (Hrs/Day) _____

Females

Last Menstrual Period: _____
# of Pregnancies: _____
Last Pap Smear: _____
Have you ever had a Hysterectomy: _____

Menopausal Symptoms: _____
# of Children: _____
Last Mammogram: _____
If yes, were your Ovaries removed: _____

Medications: _____
Drug Allergies: _____
Past medical Problems: _____
Past Operations: _____
Serious Injuries: _____
Diagnostic Studies: (X-rays, exercise, stress test, sigmodoscope, etc.) _____

Family Medical History: (Hypertension, Diabetes, Stroke, Heart disease, Lung disease, Liver disease, Kidney disease, TB, Cancer (what kind?)

Mother: _____
Grandmother: _____
Siblings: _____
Aunts: _____

Father: _____
Grandfather: _____
Children: _____
Uncles: _____

Immunizations:

Last Tetanus: _____

Last PPD: _____

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AUTHORIZED REPRESENTATIVE FORM

With my consent, Virginia Medical Alliance may call my home or other designated location and leave a message on voice mail or speak to the authorized representative listed below who can receive information pertaining to my clinical care, including test results, instructions on course of treatment and appointment reminders. With my consent, Virginia Medical Alliance may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations.

1. Name: _____

   Relation to patient: _____

2. Name: _____

   Relation to patient: _____

Please check the appropriate box if you will allow Virginia Medical Alliance to leave health information on your home phone or other designated voice mail system.

Yes _____ No _____

Please print home, work and cell phone numbers below:

Home #: _____

Work #: _____

Cell #: _____

Patient's Name (Print): _____

Patient's Signature: _____

Date: _____

5510 Alma Lane • Springfield, Virginia 22151

Phone: 703-642-5990

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by my physician at Virginia Medical Alliance, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care or to conduct health operations of Virginia Medical Alliance. P.C.

I have the right to revoke this consent in writing at any time, except for the extent that my physician or Virginia Medical Alliance, P.C. has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative/s Authority