

Centreville OBGYN

Last Name: _____ First: _____

Date of Birth: _____

Address (if different from photo ID):

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best number: Home Work Cell

Appointment reminders: Do you prefer Voicemail Text Message Both none

Email: _____

Preferred Pharmacy: _____

Address and/or phone number _____

Insurance Information

Who is the insured? Self Spouse Other: _____

If you are NOT insured, please complete the following:

Name (of the insured): _____

DOB (of the insured): _____

Address (of the insured, if different from yours): _____

Race: American Indian or Alaska Native Asian Native American or Pacific Islander

Black or African American White Hispanic Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Preferred Language: English Spanish Other: _____

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 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.

Signature: _____

Date: _____

Centreville OB/GYN

14701 Lee Highway Suite 304
Centreville, VA 20121
Phone: 703-830-4388 Fax: 703-830-4188

Medical History Questionnaire

Date _____

Patient Name: _____ DOB: _____

Reason for your visit: _____

Medications

Please list any medications that you are taking (prescriptions or over the counter):

1. _____
2. _____
3. _____

General Medical History

Please check if you have or had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gastric Ulcer | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GERD | <input type="checkbox"/> MTHFR |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headache | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> CVA | <input type="checkbox"/> High Risk Pregnancies | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV or Aids | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Infections | |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Kidney Stone | |

Centreville OB/GYN

14701 Lee Highway Suite 304
Centreville, VA 20121
Phone: 703-830-4388 Fax: 703-830-4188

1

Allergies

Please list any medication you are allergic to and severe allergies that you have:

1. _____
2. _____

Surgical History

- | | | |
|--|---|---|
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Breast Lumpectomy | <input type="checkbox"/> Cone Biopsy | <input type="checkbox"/> Endometrial Ablation |
| <input type="checkbox"/> Oophorectomy | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Myomectomy |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> D&C | <input type="checkbox"/> Gall Bladder | |

Family History

(R) Relationship to patient (mother, father, etc)

- | | |
|---|--|
| <input type="checkbox"/> No family History | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Patient is adopted | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Unknown Maternal History | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Unknown Paternal History | <input type="checkbox"/> GERD _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hypothyroidism _____ |
| <input type="checkbox"/> Birth Defects _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> CAD _____ | <input type="checkbox"/> Liver Disease _____ |
| <input type="checkbox"/> Cardiovascular Disease _____ | <input type="checkbox"/> Multiple Births _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> OA _____ |
| <input type="checkbox"/> Congenital Anomaly _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Pulmonary Disease _____ |
| <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> CVA/TIA _____ | |

Centreville OB/GYN

14701 Lee Highway Suite 304
Centreville, VA 20121
Phone:703-830-4388 Fax: 703-830-4188

2

Social History

Do you Smoke? _____ How many a day? _____
Do you drink Alcohol? _____ How often? _____
Any Caffeine Use? _____ How often? _____
Any Recreational Drug Use (If so what kind)? _____

Gynecological History

Age of first period: _____ Last Menstrual Period: _____
Frequency of cycle: _____ Days of cycle: _____
Pain with periods: _____ Recent changes in period: _____
Currently Sexually Active: _____ (Y) _____ (N)
Current Birth Control: _____
Have you had a pap within the last year? _____
If so when: _____ result: _____
Have you ever had an abnormal Pap? _____ If so when: _____
Do you do self-breast exams monthly? _____
Have you had a mammogram? _____
If so when: _____ Result: _____
Have you had a Bone Density Test? _____
If so when: _____ Result: _____

Obstetric History

How many pregnancies? _____ LMP (last menstrual period) _____
Full-Term: _____ Pre-Term: _____ Abortion(s): _____ Live Children: _____
C-Sections: _____ Vaginal Deliveries: _____ Miscarriages: _____
Pregnancy #1- Year _____, M/F _____, weight _____, gestation _____,
medicated(epidural) _____, Problems (during pregnancy) _____

Centreville OB/GYN

14701 Lee Highway Suite 304
Centreville, VA 20121
Phone: 703-830-4388 Fax: 703-830-4188

Pregnancy #2- Year ____, M/F ____, weight ____, gestation ____,
medicated (epidural) ____, Problems (during pregnancy) _____
Pregnancy #3- Year ____, M/F ____, weight ____, gestation ____,
medicated (epidural) ____, Problems (during pregnancy) _____

Please Check if any of the following apply to you now:

- Unexplained Weight change: ____gain ____loss
- Fever
- Dizzy Spells
- Trouble with eyes
- Nosebleeds
- Trouble with nose/sinuses
- Chest Pain
- Irregular and/or rapid heart beat
- Coughing up a lot of phlegm or mucus
- Coughing spells
- Trouble breathing
- Nausea
- Vomiting
- Constipation
- Feeling of incomplete emptying of stools after bowel movement
- Involuntary loss of gas or stool
- Diarrhea
- Blood in stool
- Heartburn/Indigestion
- Pain with Intercourse
- Bleeding with Intercourse
- Abnormal vaginal discharge
- Vaginal odor, itching, dryness

Centreville OB/GYN

14701 Lee Highway Suite 304
Centreville, VA 20121
Phone: 703-830-4388 Fax: 703-830-4188

- Irregular periods, heavy periods
- Pain or severe cramping with periods
- Severe premenstrual symptoms
- Bloating and/or excess gas
- Pelvic and/ or abdominal pain
- Involuntary urine loss
- Painful and/ frequent urination
- Feeling of incomplete bladder empty
- Blood in urine
- Trouble with balance
- Severe joint or muscle pain
- Changes in skin lesions (warts, moles)
- Breast pain
- Nipple discharge
- Migraine headaches
- Awaken with headaches
- Trouble sleeping
- Hot Flashes
- Night Sweats
- Difficulty Concentrating
- Hair loss or thinning
- Increased body or facial hair
- Decreased sex drive
- Difficulty achieving orgasm
- Loose feeling of the vagina with or without decreased feeling during sex
- Partner complaining of the above
- Sensation of something bulging or falling from vagina
- Labia (vulvar lips) too long or excessive
- Unusual fatigue
- Heat or cold tolerance
- Frequent bruising

Centreville OB/GYN

14701 Lee Highway Suite 304
Centreville, VA 20121
Phone:703-830-4388 Fax: 703-830-4188

- Domestic Violence- victim of sexual assault/rape ___ yes ___ no
- Do you take calcium supplements? ___yes ___no
- Do you Exercise? ___yes no___
- Do you wear a seatbelt? ___yes ___no

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**

Centreville OB/GYN

14701 Lee Hwy, Suite 304
Centreville, VA 20121

Patient Responsibilities and Office Policies

Please read and initial acknowledgment of each office 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 \$10.00 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 is abnormal will require a consultation appointment to discuss the 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 \$250.00 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 your co-payment.
- _____ 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 tests 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 regulations. 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 filing a claim with your insurance company for reimbursement. Of you will have to reschedule your appointment.
- _____ A \$15.00 fee is required for **ALL** lost prescriptions and referral forms (i.e. Radiology orders and orders for other doctors).

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

Signature

Date

Thank you in advance for your cooperation and understanding.

Revised 09/2016