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:

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

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Allergies

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

1. _____ _____
2. _____ _____

Surgical History

__ Mastectomy
__ Breast Lumpectomy
__ Oophorectomy
__ Hysterectomy
__ D&C
__ Hernia
__ Cone Biopsy
__ Laparoscopy
__ Tubal Ligation
__ Gall Bladder
__ Appendectomy
__ Endometrial Ablation
__ Myomectomy
__ Other_____

Family History

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

__ No family History
__ Patient is adopted
__ Unknown Maternal History
__ Unknown Paternal History
__ Alcoholism _____
__ Anemia _____
__ Asthma _____
__ Birth Defects _____
__ CAD _____
__ Cardiovascular Disease _____
__ Cancer _____
__ Congenital Anomaly _____
__ COPD _____
__ Crohn's Disease _____
__ CVA/TIA _____
__ Depression _____
__ Diabetes _____
__ Epilepsy _____
__ GERD _____
__ High Blood Pressure _____
__ High Cholesterol_____
__ Hypothyroidism _____
__ Kidney Disease _____
__ Liver Disease _____
__ Multiple Births _____
__ OA _____
__ Osteoporosis _____
__ Pulmonary Disease _____
__ Other _____

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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) _____

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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

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- ☐ 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

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- 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**

Neda Hashemi MD F.A.C.O.G.
14701 Lee Highway Suite 303-304
Centreville, VA 20121

Date: _____

I, _____ hereby authorize Centreville OB/GYN 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
- ❑ Email _____

May leave message to return call to physicians 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

Neda Hashemi MD F.A.C.O.G.
14701 Lee Highway Suite 303-304
Centreville, VA 20121

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 the 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 Signature: _____ Date: _____

Patient Name: _____

Neda Hashemi MD F.A.C.O.G.
14701 Lee Highway, Suite 303-304
Centreville, VA 20121

NOTICE TO OUR PATIENTS

For Annual/Well-Woman Exam:

An Annual gynecological exam, known as "preventative management (PM)" for insurance purposes consists 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 tests performed 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 test is performed during the visit. HPV is a sexually transmitted disease (STD). Gonorrhea and Chlamydia are also STD's and 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 and etc.)

For woman 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.

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" medical conditions, in which case I will be responsible for payment to the office and the laboratory for services rendered.

Print Name: _____ Birth Date: ___/___/___

Signature: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

Neda Hashemi, MD
14701 Lee Highway, Suite 304
Centreville, VA 20121

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

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

Name _____ Birthdate _____

Signature _____ Date _____

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