Completed Date: ___________________

PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other: ________ Patient*: ______________________________ Suffix: Jr./Sr./Other: __________
Last First Middle Initial
Previous Name: ______________________________ Preferred Name: ______________________________
Mailing Address*: ____
Street Address 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*: ______________ 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*

Email: ____
Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other: ______________
Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: ______________________
Language*: ☐ English ☐ Spanish ☐ Other: ______________________
Pharmacy Name*: ______________________ Address: ______________________ Phone #:
Street Address City State Zip

Emergency Contact*

Name: ______________________________________ Relationship: ______________________
Last First
Address: ____
Street Address City State Zip
Home #: ______________________ Work #: ______________________ Cell #: ______________________

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name: ______________________ Date of Birth: ______________ Sex: ________ Social Security # ------------------- ______
Last First mm/dd/yyyy
Address: ____
Street Address City State Zip
Home #: ______________________ Cell #: ______________________ Work #: ______________________ Ext: __________

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: ______________ Sex: ________ Social Security # ------------------- ______
Last First mm/dd/yyyy
Relationship to Insured: ______________________ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Address: ____
Street Address 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: ______________ Sex: ________ Social Security # ------------------- ______
Last First mm/dd/yyyy
Relationship to Insured: ______________________ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Address: ____
Street Address 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)**

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)

211 Gibson Street, NW · Suite 215 · Leesburg · VA · 20176

Phone: (571) 707-2085

Fax: (571) 291-9196

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:**

Patient Information

Date of Visit: ______________________________
Patient's Full Name:
____

Date of Birth: ____________________________________

Height:_______Weight:________Blood Type: ________

Last Menstrual Period: ________________

Social History:

Do you drink alcohol?	Yes	No
If yes, how often do you drink:		
Do you smoke?	Yes	No
If yes, how often do you smoke: (Include type (Cigarettes, Cigars, Pipe, Vapor)		
Do you work? (Include full time, part time and type of occupation)		

Pharmacy Information

Pharmacy Name:
____

Phone Number: _________________________

Pharmacy Address: ____________________________

Allergies: (List all medication, food and environment

Medications:

Name:	Reason for taking:	Prescribed by:

Patient and Family Medical History: (Mark an X under self or family member for the conditions.)

	Self	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Attention Deficit Disorder							
Anemia							
Asthma							
Alcoholism							
Diabetes Mellitus							
Vertigo							
Depression							
Emphysema							
Epilepsy							
High blood pressure							
High cholesterol							
Lyme Disease							
Migraines							
Stroke							
Thyroid Problems							
Deceased							

Please list another other self or family medical history:
____

211 Gibson Street, NW · Suite 215 · Leesburg · VA · 20176

Phone: (571) 707-2085

Fax: (571) 291-9196

AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name ____

SS#____

Date of Birth____

INSTRUCTIONS FOR LEAVING MESSAGES
AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION

OK to communicate with spouse? YES NO

Spouses Name____

OK to leave information on answering machine? YES NO

OK to communicate with parent/children? YES NO

Name(s)____

OK to communicate with caregiver? YES NO

Name____

OK to communicate with any other person(s) YES NO

Please list____

Communicate only with me YES NO

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING

Signature____

Date____

Other Comments____

____

____