MEDICAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present Health or Cause of Death	MOTHER	Present Health or Cause of Death	SPOUSE	Present Health or Cause of Death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		HOW MANY DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		HOW MANY DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		HOW MANY DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

5 MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

6 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date

PRIMARY CARE DOCTORS GROUP, P.C.
2616 SHERWOOD HALL LANE
SUITE 303
ALEXANDRIA, VA 22306
PHONE: 703-799 1118 FAX: 703-799 1586

Dr Bejjenki Chary Dr Aladdin Bolad Jennifer Barnwell, NP

RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION SUCH AS MY MEDICAL HISTORY, TEST RESULTS, DIAGNOSES, PRESCRIPTIONS AND ALL PERTINENT RECORDS TO MY ATTENDING PHYSICIAN.

PLEASE FORWARD ALL MEDICAL RECORDS TO THE ABOVE ADDRESS

PATIENT:_____ DOB:_____

ADDRESS:_____

_____

SIGNATURE_____ DATE_____

PRIMARY CARE DOCTORS GROUP, P.C.
106 IRVING STREET, NW
SUITE 309 SOUTH TOWER
WASHINGTON, D.C. 20010
PHONE: 202-291 3122 FAX: 202-291 0655

Dr Bejjenki Chary Dr Aladdin Bolad Jennifer Barnwell, NP

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PLEASE FORWARD ALL MEDICAL RECORDS TO THE ABOVE ADDRESS

PATIENT:_____ DOB:_____

ADDRESS:_____

_____

SIGNATURE_____ DATE_____

HIPPA Policy

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

My Protected Health Information may be disclosed to:

_____ Self only

_____ Spouse/Significant Other (Please list below)

_____ Parent/Guardian (Please list below)

If Spouse/Significant Other or Parent/Guardian, please list name and phone #

By signing this form, I understand the above information and agree with its contents for the HIPPA Disclosure Form.

Signature_____ Date_____

FINANCIAL POLICY

WE ACCEPT CASH, CHECKS, MONEY ORDERS & MOST CREDIT CARDS

Regarding Insurance

This office accepts assignment of insurance benefits. Your insurance claim will be filed for you as a courtesy. Once we receive an Explanation of Benefits from your carrier, a statement indicating any remaining balances will be mailed to you within 30 days. Payment is due upon receipt. Your responsibility as determined by your insurance policy is a contract between you and your health insurance carrier. If for any reason insurance carrier refuses or fails to pay the estimated fee, the balance is then your responsibility. If there is a credit on your account with outstanding insurance, a refund will not be issued until all insurance payments are final.

ESTIMATED PATIENT PORTION ON ACCOUNTS IS DUE AT THE TIME SERVICES ARE RENDERED

Confirming and Missed Appointments

If your appointment is not cancelled at least 24hours prior to your appointment your account will be charged a $50.00 fee. All fees must be paid prior to your next appointment. Our office also requires all appointments be confirmed 24 hrs. prior.

Delinquent Accounts

If an unpaid balance exists for more than 90 days it is considered delinquent. Delinquent accounts will be assessed an additional charge of 33% of the outstanding balance, not to include court costs and attorney fees that may also be incurred. Returned checks on accounts will be charged a $35 fee and must be paid in cash, money order or credit card. If payment is not received within 7 days your account will be forwarded to the States Attorney's Bad Check Restitution Program.

Patient Signature_____ Date_____