Registration Form

Patient Name _____ Soc Sec # _____

Address _____ City _____ State _____ Zip _____

Sex: □ M □ F Age _____ Birthdate_____ □ Single □ Married □ Widowed □ Separated □ Divorced

Home Phone _____ Cell Phone _____ Work Phone _____

PREFERRED LANGUAGE: (Select one) ENGLISH_____ SPANISH_____ OTHER :_____

RACE: (Select one) **W**hite____ **C**aucasian____ **A**frican **A**merican _____ **S**panish/**H**ispanic_____ **A**sian_____ **O**ther_____

ETHNICITY: (circle one) NOT HISPANIC HISPANIC/LATINO REFUSE TO REPORT

Email Address_____

Patient's Employer _____ Occupation _____

Business Address _____ Work Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

Primary Insurance Company

Person Responsible for Account _____ _____

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Address _____ City _____ State _____ Zip_____
(If different than patient)

Person Responsible Employed by _____ Occupation _____

Business Address _____ Work Phone _____

Insurance Co _____ Group # _____ Member # _____

Secondary / Supplementary Insurance Company

Is patient covered by additional insurance? □ YES □ NO Subscriber Name_____

Insurance Co _____ Group # _____ Member # _____

Please Read and Sign the Following statement

I hereby authorize direct payment of medical benefits to Manassas Internal Medicine for services rendered by Him/Her in person or under his/her supervision.
I understand that I am financially responsible for any balance nor covered by my insurance. I hereby authorize Manassas Internal Medicine to release any medical or incidental information that may be necessary for either medical care or financial benefits. I request that payment of authorized benefits be made on my behalf.
I understand that the office requires 24 hour notice for cancel or rescheduled appointments. By not providing the required notice I understand their will be a $25 charge added to my account.
I certify that the information given by me in applying for payment is correct. A photo copy of these assignments shall be valid as the original. Should any of this information change, I am responsible for notifying this office in a timely fashion.
I understand that I am responsible for any collection fees associated with balance on my account.
I agree that I am fully responsible for payment for all services rendered to me. If my account is referred to collections I will pay, in addition to the original amount owed, all cost of collection including attorney's fees equal to 30% of the debt owned.

Signature _____ **Date**_____

Manassas Internal Medicine

Privacy Disclosure Form

Client Name:

_____

Manassas Internal Medicine (MIM) respects your right to privacy. You, as a client, have the right to make certain choices about the uses and disclosures of your health information. Any information you authorize for use and disclosure may be re-disclosed and is no longer protected. You may amend your elections for restrictions by contacting the Privacy Officer.

- I authorize and consent to the release of my health information to the following individuals:

_____ _____ _____

Name of Person or Persons

- I would like to receive all written communications at the following location rather than my home address (if none specified, written communications will be forwarded to your home address):

_____

P.O. Box or Street Address, City, State, Zip

I would like to receive appointment reminders and patient care follow-up communications only by the following means (*check all that apply*):

- ☐ Mail
- ☐ Home Phone ( ) _____
- ☐ Work Phone ( ) _____
- ☐ Cell Phone ( ) _____

NOTE: Manassas Internal Medicine reserves the right to implement stricter privacy standards under certain circumstances which it deems necessary for the protection of the patient.

****

I acknowledge that I have been given the Manassas Internal Medicine NOTICE OF PRIVACY PRACTICES and have had the opportunity to ask questions about the information provided in the notice. I understand that I have the right to request other reasonable requests regarding confidential communications by contacting the Privacy Officer as specified in the NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship

Effective 4/14/2003

Manassas Internal Medicine Patient Questionnaire

Name:_____**DOB**:___/___/_____**Gender**: _____ **Date**:_____

Reason for Visit: _____

_____

_____

Past Medical History:

☐Alcoholism	☐Back Problems	☐Epilepsy	☐High Cholesterol	☐Osteoporosis
☐Anxiety/Depression	☐Blood Disorders	☐Glaucoma	☐Kidney Disorder	☐Stroke
☐Arthritis	☐Cancer	☐Heart Disease	☐Liver Disorder	☐Skin Disorder
☐AIDS/HIV	☐Diabetes	☐Hypertension	☐Lung Disorder	☐Thyroid Disorder

Medications

Name	Dose	Frequency

Allergies:

Name of Medication	Reaction

Surgical History _____

Colonoscopy: _____

Women: _____ _____

Last Pap **Last Mammogram**

Family History

Do you have a family history of any of the following conditions? (Check all that apply)

☐Alcoholism	☐Back Problems	☐Diabetes	☐High Blood Pressure	☐Lung Disease
☐Anemia	☐Cancer	☐Genetic Disorder	☐High Cholesterol	☐Osteoporosis
☐Anxiety disorder	☐Blood disorders	☐Glaucoma	☐Kidney Disorder	☐Stroke
☐Arthritis	☐Depression	☐Heart Disease	☐Liver disorder	☐Thyroid Disorder

If you checked any of the above conditions, please identify who in your family has the condition(s).

_____

Social History

Tobacco use: ☐Current ☐Former ☐Never Packs per day:_____ Alcohol use: ☐Yes ☐No # of drinks/week _____

Currently sexually active? ☐Yes ☐No # of partners in the past year_____ Would you like STD screening today? ☐Yes ☐No

Recreational drug use: ☐Yes ☐No Which drug(s)?_____ # of times/week_____

Caffeine intake: # of drinks/day_____ How often do you exercise? # of times/week _____