Account Number:_____

3198 Pacific Avenue, Suite 104
Virginia Beach, VA 23451
Phone: 757-428-1911 Fax 757-470-5977

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

ADDRESS: _____ CITY: _____ ZIP:_____ STATE:_____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

PREFERRED NUMBER (CIRCLE): **CELL** **HOME** OK TO LEAVE MESSAGES (CIRCLE): **AT HOME**: YES NO **ON CELL**: YES NO **AT WORK**: YES NO

EMAIL: _____

EMERGENCY CONTACT NAME: _____

PHONE NUMBER: _____RELATIONSHIP TO PATIENT:_____

GUARANTOR (TO WHOM STATEMENTS ARE SENT):_____

GENERAL INFORMATION

PRIMARY LANGUAGE: □ ENGLISH □ SPANISH □ OTHER: _____
ETHNICITY: □ HISPANIC □ NON-HISPANIC □UNKNOWN □ DECLINE
RACE: □ AMERICAN INDIAN/ALASKAN NATIVE □ ASIAN □ BLACK/AFRICAN AMERICAN □ WHITE/CAUCASIAN
□ OTHER PACIFIC ISLANDER □ OTHER RACE □ DECLINE

INSURANCE INFORMATION

PRIMARY INSURANCE:
COMPANY NAME:_____POLICY # :_____
POLICY HOLDER NAME _____ POLICY HOLDER DATE OF BIRTH _____
RELATIONSHIP TO POLICY HOLDER □ SELF □ SPOUSE □ CHILD □ OTHER

SECONDARY INSURANCE:
COMPANY NAME:_____POLICY # :_____
POLICY HOLDER NAME _____ POLICY HOLDER DATE OF BIRTH _____
RELATIONSHIP TO POLICY HOLDER □ SELF □ SPOUSE □ CHILD □ OTHER

NAME OF PERSON(S) AUTHORIZED TO RECEIVE INFORMATION (permission for protected health information to be disclosed for purposes of communicating results, findings and care decisions to family members or others listed):

_____

ACKNOWLEDGEMENT/ AUTHORIZATION I give consent to the physician to provide and perform such medical and/or surgical care, test, procedure, prescriptions, and other services and supplies that are deemed necessary or beneficial by my physician for my health and well being. I give my authority to download my medication history and consent to registering immunizations into VIIS (Virginia Immunization Information System) I have read and understand the office's Notice of Privacy Practices I authorize my provider's office to contact me by telephone to remind me of my appointments. A $25 no-show fee will be applied to all missed appointments that have not been cancelled within 12 hours of the scheduled appointment time. I authorize my insurance benefits to be paid directly to the physician and I authorize the release of medical information required to process my claims. The above information is true to the best of my knowledge.

Patient Signature:_____ **Date**: _____

The Doctor's In

Patient History

Patient Name: _____ Today's Date:_____

Date of Birth _____/_____/_____ Occupation:_____

Marital Status: _____

Reason for today's visit:_____

Do you have any other health concerns? Please list:_____

Please list any allergies (medications, food, bee stings, latex, etc): _____

Medical History

Please list all current medications (prescription and over the counter) that you are currently taking

Drug Name	Strength	Frequency Taken

Please list any surgeries you have had (including C-section)

Type of Surgery	Reason	Year

Please check conditions that doctors have followed you for in the past

	High blood pressure/ hypertension		High Cholesterol		Liver Disease
	Thyroid Problems		Kidney Disease		Heart Attack/ By-pass Surgery
	Heart Failure		Heart Murmur		Mitral Valve Prolapse
	Stroke		Seizures/ Epilepsy		Stomach Problems
	Intestinal Problems		Reflux Disease		Glaucoma
	Psychiatric Illness		Arthritis		Abnormal PAP
	Diabetes ("sugar")				
	Cancer (Type and Location):				
	Other (please list):				

Preventative Care (when was your last):

	Year		Year		Year
Tetanus Booster		Flu Shot		Pneumonia Vaccine	
Colonoscopy		Bone Densitometry		Cardiac Stress Test	
Chest X-ray		Eye Exam		Shingles Vaccine	

Females Only

	Year		Year
Last Mammogram		Number of live births	
Last PAP smear		Number of miscarriages	
Number of Pregnancies		Number of abortions	

Social Habits

Are you a **current** or **former** tobacco user? (circle)	Do you use illicit drugs? (circle)	**YES NO**
If yes, how many years?	If yes, what type?	
If yes, what type? (circle) Chew Cigarettes Cigar E-cig/Vape	If yes, how often?	
If yes, how much?	Number of alcoholic drinks per week	
Do you identify as (circle): **Male Female Other** (please explain)		
Do you identify as (circle): **Straight/Heterosexual Gay/Lesbian/Homosexual Bisexual Other**		

Family History

Please check all that apply	**Mother**	**Father**	**Maternal GMa**	**Maternal GPa**	**Paternal GMa**	**Paternal GPa**	**Siblings** (please specify)	**Other**
High Blood Pressure/ Hypertension								
Heart Attack/ Heart Surgery								
Diabetes								
Stroke								
Cancer (type)								
Osteoporosis								
Thyroid Problems								
Mental Illness								
Glaucoma								
Other								

Please check YES or NO

GENERAL	**YES**	**NO**	**SKIN**	**YES**	**NO**	**MUSCULOSKELETAL**	**YES**	**NO**
Fever			Rash			Joint swelling		
Sweats			Changing mole			Joint pains		
RESPIRATORY			Itching			Muscle pains		
Cough			Slow healing wounds			**ALLERGY**		
Shortness of breath			**CARDIOVASCULAR**			Itchy eyes		
Wheezing			Chest pain or pressure			Runny nose		
Shortness of breath w/ exertion			Ankle swelling			Nasal congestion		
EAR/ NOSE/ THROAT			Palpitations			Post nasal drip		
Ear pain			Easy bruising			**NUTRITION**		
Hearing loss			Easy bleeding			On a special diet		
Difficulty swallowing			**DAILY LIVING**			Weight loss gain < > 10 lbs		
GENITOURINARY			Violence in your home			Change in appetite		
Urinary frequency			Changes in functional ability			**EYES**		
Burning in urination			**ENDOCRINE SYSTEM**			Changing vision		
Blood in urine			Excessive thirst			**GI SYSTEM**		
Problems with sex			Fatigue			Nausea		
Exposure to STD			Temperature intolerance			Vomiting		
MENTAL HEALTH			**NEUROLOGIC SYSTEM**			Diarrhea		
Insomnia			Numbness			Constipation		
Depression			Headaches			Abdominal pain		
Anxiety			Lightheaded/dizzy			Blood in stool		
Suicidal thoughts								
OTHER (please list):								

Financial Agreement and Consent

Thank you for choosing The Doctor's In for your health care needs. We believe it is important for you to have a clear understanding of our treatment, release of information and payment policies. Please read and sign the following statement.

Treatment Policy I understand that I have a health problem that requires diagnosis and treatment in The Doctor's In outpatient facility. I voluntarily consent to and authorize such diagnostic procedures and medical care ordered by the physician providing services to me in this facility, which in the physician's opinion are necessary to treat my health problem. I hereby consent to have my blood tested for infectious disease if a health care worker is accidentally exposed to my blood of body fluids. Virginia State Law requires it to be tested for Hepatitis B, C, and HIV, and that the results of these test are given to the person who was exposed. It also requires that a health care worker give the results of the HIV test to me in person so I will have the opportunity to ask questions about the test results. No guarantees have been made to me as to the results of examination or treatment provided to me in this facility. I understand that I may be released from this facility before all of my medical problems are known or treated as it is my responsibility to make arrangements for follow up care.

Release of Information and Insurance Benefits I authorize and consent to the release of my general health care records to the extent the records are needed for billing, collection, or payment of claims under Virginia Law. I further authorize payment directly to The Doctor's In P.C. of health insurance benefits otherwise payable to me. I further authorize and consent to the release of my medical records to the referral practitioners or medical facility responsible for any necessary follow-up care.

I also give permission to:

1. Leave a message on my voicemail asking me to call the office or remind me of an upcoming appointment.
2. Release my minor child's immunization record and/or medical treatment plan to child's school or daycare center; and the transmission of the "Physician Request for Administration of Medication" to the school nurse or day care provider when needed. _____ (initials)
3. Release any and all medical and/or charge information needed by my insurance carrier: a) to determine my eligibility for coverage of treatment I received from The Doctor's In or wish to receive from a referral physician, b) for quality review required by federal regulation of HMO's or c) utilization management, or continuing care oversight.

Financial Agreement In consideration for the services rendered and to be rendered to me by The Doctor's In or physician, I agree to pay for all charges incurred on my behalf in accordance with The Doctor's In charges. I also understand that The Doctor's In may modify its charges from time to time, and I agree to pay modified charges for services rendered to me. If I am married, I agree that my obligation to pay is for necessary services in the interest of the marriage and the family. I agree that my obligation to pay shall exist regardless of and independent from any private contractual agreements between me and any insurance carrier, public body or third party not signing this agreement. I also hereby request that a payment authorized benefits be made on my behalf by a third party payer. I recognize and acknowledge that payment shall be due upon receipt of The Doctor's In bill. Submission of my bill by The Doctor's In to any third party payer shall not be deemed an agreement to defer payment or to extend credit to me by The Doctor's In. If my account with The Doctor's In is referred to an attorney or collection agency for enforcement of my obligation to pay, I agree to pay reasonable attorney's fees and collection expenses up to 33% of my balance. I acknowledge that all accounts are due and payable in full sixty (60) days from the date of service of the patient from The Doctor's In. I understand and acknowledge that there is an exception to this section for patients who are covered by CHAMPUS, CHAMPVA, Medicare, and Medicaid. I am responsible for any charges not covered by my insurance, including copayments, deductibles, and fees for non-covered services. I am also aware that the HMO insurance plans specifically require co-payments be paid at the time of service. The patient portion of other insurance plans is also expected to be paid at the time of service. Any balance remaining on the account after insurance pays is due upon receipt of the billing statement. Patients with plans we do not file will be given the information they need to file their own claim.

Self Insured Patients I acknowledge that this provider is considered to be out of network for my plan or I acknowledge that I do not have health insurance and elect to receive care. I understand that I will be responsible for payment of charges in full or for the remaining balance after out of network/deductible benefits are applied (if any).

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ THIS AGREEMENT, UNDERSTANDS ITS CONTENTS AND SIGNIFICANCE, AND IS COMPETENT TO EXECUTE IT,OR AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Signature of Patient:_____ **Date**: _____

IF THE PATIENT IS A MINOR OR UNABLE TO CONSENT, COMPLETE AND SIGN THE FOLLOWING:

Reason patient is unable to sign:_____

Signature of person signing on behalf of the patient: _____

Name and Relationship to patient:_____

The Doctor's In Representative Witness_____

THE DOCTOR'S IN

3198 Pacific Avenue, Suite 104
Virginia Beach, VA 23451
Phone: 757-428-1911 Fax 757-470-5977

Medication Policy

PATIENT NAME: _____ **DATE OF BIRTH**:_____/_____/_____

As your healthcare provider, I reserve the right to evaluate the cause of your pain and make treatment recommendations that may or may not include the use of opiods (narcotics). This means that medication prescribed to you must be taken as directed. If you take more than directed or misuse any prescribed medication, early refills will not be approved. Medication misuse will result in discharge from my practice.

If you are required to schedule routine evaluations to treat your medical condition, you must schedule your appointments accordingly. Do not call the office for refills before the appointment and/ or refill date.

Opioid prescriptions, once written, will NOT be replaced if lost.

If you phone in early for refills, we will not oblige

You may be subject to periodic drug testing. We routinely communicate with pharmacist, other physicians, insurance companies, and the Drug Monitoring Program of Virginia. If we should learn that you are going to more than one pharmacy or physician and getting pain medication of any kind from another prescriber, you will be asked to leave the practice. Any laboratory evidence of the use of illegal substances will result in immediate discharge from the practice and appropriate legal authorities will be notified.

Please keep your medication in a safe place and remove labels before you discard empty bottles.

I have had an opportunity to ask questions and agree with all of the above.

Patient Signature:_____

Patient Printed Name:_____ **Date**:_____

Physician Signature:_____ **Date**:_____