

# Patient Registration Form

Patient's Name (Last, First, MI): _____	
Patient's Home Phone Number: _____ Alternate Phone Number ( <input type="checkbox"/> cell or <input type="checkbox"/> work): _____	
E-Mail Address: _____	
Address: _____ Apt. # _____	
City: _____ State: _____ Zip: _____	
Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Patient's Employer: _____	Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other: _____
Emergency Contact: _____ Relationship to Patient: _____ Address: _____ Phone number: _____	
<b>INSURANCE INFORMATION</b>	
Primary Insurance: _____ Patient is Subscriber/Policy Holder: Y N	Secondary Insurance: _____ Patient is Subscriber/Policy Holder: Y N
<b>INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card</b>	
Subscriber/Policy Holder: _____ Relationship to Patient: _____ Address: _____ Social Security Number: _____ Date of Birth: _____ His or Her Employer: _____ Work Phone Number: _____	
<b>RELEASE OF INFORMATION</b> I hereby give permission to the person(s) listed below to receive information about the care of the above named patient. Name(s): _____ Relationship to Patient: _____	
Inova Medical Group reserves the right to charge a fee for any scheduled visits that are: 1. Cancelled with less than 24 hours notice 2. Are missed without calling to cancel ( no show) Cancellation Fee schedule: New Patient \$50.00; Established Patient: \$35.00 Patient / Parent or Guardian Signature: _____ Date: _____	

Personal Information

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Occupation \_\_\_\_\_ Marital Status: \_\_\_\_\_ Name of Partner/Spouse: \_\_\_\_\_

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian [ ] Other: \_\_\_\_\_

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: \_\_\_\_\_

Number of children: \_\_\_\_\_ Children's Names/Ages: \_\_\_\_\_

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor: \_\_\_\_\_

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): \_\_\_\_\_

Preferred **Pharmacy**: \_\_\_\_\_

Date of Last Complete Physical Exam: \_\_\_\_\_ Date of Last Blood Work: \_\_\_\_\_

Date of Last Colonoscopy: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

**For Females:** Date of Last Menstrual Period: \_\_\_\_\_ Date of Last Pap Smear: \_\_\_\_\_

History of Abnormal Pap (list date/s)? \_\_\_\_\_ Date of Last: Mammogram: \_\_\_\_\_ DEXA: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Terminations: \_\_\_\_\_ Living Children: \_\_\_\_\_

Method/s of Contraception: \_\_\_\_\_

If YOU or a FAMILY MEMBER has had any of the following, please circle and indicate which family member when applicable:

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Type 1 or 2 Diabetes	<input type="checkbox"/>	Respiratory Disease
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	Skin Disease
<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	Gynecological Disease	<input type="checkbox"/>	Stomach/Colon Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Cancer, Type/s	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	
<input type="checkbox"/>			Osteopenia/Osteoporosis		

Please list any SURGERIES you have had and include the month/year:

Social Information

Tobacco Use: Do you smoke? \_\_\_\_\_ If so, how many cigarettes/cigars per day: \_\_\_\_\_ No. of years smoking: \_\_\_\_\_ Do you chew tobacco? \_\_\_\_\_ Have you thought about quitting? \_\_\_\_\_ Have you quit before? \_\_\_\_\_ How long? \_\_\_\_\_

Alcohol Use: Do you drink alcohol? \_\_\_\_\_ If so, what type? \_\_\_\_\_ How many in 1 week? \_\_\_\_\_ Drug Use: Any history of illegal drug use? \_\_\_\_\_ If so, what type/s? \_\_\_\_\_ When? \_\_\_\_\_ Do you exercise? \_\_\_\_\_ What activities do you do, and how often in 1 week? \_\_\_\_\_

Are you on any special diet? \_\_\_\_\_ If so, what? \_\_\_\_\_

Do you consume any caffeinated products? \_\_\_\_\_ If so, what and how much per day? \_\_\_\_\_ Have you recently noticed an increase in sadness or gloominess? \_\_\_\_\_

Have you lost interest in enjoyable activities? \_\_\_\_\_

Do you have a living will? \_\_\_\_\_ If yes, please provide us a copy.

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Inova Health System (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Inova Health System (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Inova Health System for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students**- I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Inova Health System's education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova Health System. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Inova Health System, unless specifically rescinded in writing by me.*

Patient Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at [www.inova.org](http://www.inova.org). I may request that a copy be mailed to me by calling **703-204-3342**.

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM  
ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

CAT #84498 / R032103  
PKGS OF 100  
MR 32-06