PATIENT MEDICAL HISTORY

FD Initials:_____ Clinic Initials: _____

Name: _____ Date of Birth: _____

Date: _____ Account #: _____

Pharmacy of Choice and location: _____ Phone Number: _____

CURRENT MEDICATION HISTORY-Please List ALL Medications you are presently taking to include over the counter, herbs, supplements)

☐ **NO MEDICATIONS**

Medication & Dosage	Frequency	Medication & Dosage	Frequency

PAST MEDICAL HISTORY-Do any of these Medical Problems below apply to you? Please check box to the left of those that apply.

☐ **No Past Medical History**
☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ AFib/Irregular/Fast Heartbeat
☐ Asthma
☐ Bleeding Tendency
☐ Blood Clots Where?:_____
☐ Cancer: Type: _____ ☐ Active ☐ Remission
☐ Cardiac Catheterization
☐ Chronic Leg Swelling
☐ Diabetes
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ MRS
☐ Pacemaker Placement
☐ Seizures
☐ Shortness of Breath
☐ Sleep Apnea CPAP?:_____
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis

Other History:_____

ALLERGIES-Please list any medication, food or substance allergies and reactions

☐ **NO ALLERGIES**

ALLERGIES	Anaphylaxis	Nausea/ Vomitting	Hives/Rash	Shortness of Breath	Other: Please list

PAST SURGICAL HISTORY-Please list any past surgeries and the year

☐ **NO SURGERIES**

Surgery	Year	Surgery	Year

Please indicate the existence of the following conditions in your immediate family (parents, siblings, grandparents)

	Yes	No	Family Member
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Cancer: list			

Do you currently smoke? ____Yes ____No If no, have you ever smoked? ____Yes ____No
Use of e-cigarettes/vaping? ____Yes ____No
Do you drink alcohol? ____Yes ____No ____Socially
Illicit drug use? ____Yes ____No

Patient/Guardian Signature: _____

BLUE RIDGE
ORTHOPAEDIC &
SPINE CENTER

Patient Consent and Release of Information

I understand and have been provided with a *HIPAA Privacy Notice* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize Blue Ridge Orthopaedic & Spine Center to release my protected health information to the person(s) listed below over the phone, in person or via mail. This authorization shall expire two years from the date of signature.

☐Self: _____ Phone: _____
☐Spouse/Significant Other: _____ Phone: _____
☐Adult Child: _____ Phone: _____
☐Primary Care Physician: _____ Phone: _____
☐Specialist: _____ Phone: _____
☐Other: _____ Phone: _____
☐No release of medical information at this time

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the practice's Privacy Officer at 52 West Shirley Avenue, Warrenton Virginia, 20186. Revocations are not effective until received by the Privacy Officer. The revocation must include the patient's account number, name, address, the date of the original authorization, the recipients of the original authorization, the date of the revocation and the patient's signature. Blue Ridge Orthopaedic & Spine Center will accept written revocations of this authorization via: U.S. mail, in person, or by fax.

Patient Contact

As part of my health care treatment, I understand the office may try to contact me by phone. **Please check the following:**

- Yes ☐ No ☐ It is acceptable to leave a message regarding my protected health information including test(s) results on my voicemail.
- Yes ☐ No ☐ It is acceptable to leave a message regarding my protected health information including test(s) results with a member of my household.
- Yes ☐ No ☐ It is acceptable to discuss my protected health information with the emergency contact person that I have listed in the event that the office cannot reach me at the home/work number(s) that I have provided.
- Yes ☐ No ☐ It is acceptable for a member of my household to pick up my written prescription.
- Yes ☐ No ☐ It is acceptable to communicate via text, email or through the patient portal where applicable.

Advance Directive, Living Will, Do Not Resuscitate

Our physicians and medical providers honor our patients' end-of-life wishes, including Advance Directives, Living Wills and resuscitation desires. Please check the appropriate section if you have any of the following documents.

_____Advance Directive _____Living Will _____Do Not Resuscitate (DNR) _____Not applicable

Prescription Eligibility Acknowledgment

I am aware Blue Ridge Orthopaedic Associates and it's aaffiliated Providers will be obtaining prescription eligibility information at each office visit. This will provide basic prescription benefits and history information from my insurance (if applicable) for prescribing purposes.

I fully understand and accept/decline the terms of this consent listed above.

_____ _____
Patient/Guarantor Signature Date

BLUE RIDGE
ORTHOPAEDIC &
SPINE CENTER

Credit Policy

Our credit policy is designed to provide a clear understanding that the patient is ultimately responsible for payment of all medical services. Payment of service can be charged to your Visa, Master Card, or Discover credit cards. Blue Ridge Orthopaedic & Spine Center is very sensitive to situations in which special payment arrangements may be necessary but must be approved by our credit manager before treatment can occur. All unpaid balances not paid in 30 days (except for qualified insurance claims) may be charged a finance charge of 1% per month. There will be a $35.00 charge assessed for all returned checks. In order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Health Insurance Coverage

We participate with ***most*** major insurance companies, including workers compensation and as a courtesy will submit all valid claims with the appropriate insurance company. The guarantor and/or patient shall be responsible for any and all costs in connection with collection agency fees and attorney fees which may be required to satisfy the unpaid balance. Insurance copays are due at the time of service for each appointment. If you are not prepared to make your copay, there will be an additional $10.00 fee billed to your account.

Insurance Referrals

If your insurance company requires a referral to a specialist, please have the referral processed through your Primary Care Physician prior to your scheduled appointment with our office. Failure to obtain your referral prior to your appointment, may result in rescheduling your appointment for a later date. If you have any questions regarding your insurance referral, please contact your insurance company.

Personal Pay (Non- Insured)

Our primary responsibility is to provide the patient with the best possible medical treatment and to effectively control rising health care costs; we expect payment at time of service for all non-insured patients. Non-insured patients will be required to make a ***deposit for each visit, at the time of check in.*** After this deposit, any additional charges for your visit will be billed. Additional charges can accrue based off of the complexity of your visit/doctor exam, if you are a new or returning patient and if special procedures are performed at our office. The costs of these procedures are separate and not included in your office visit. You can refuse to have a procedure performed, and we can provide you with an estimate prior to a procedure being performed. If the balance cannot be paid in full, arrangements must be made with our credit manager. Non-insured patients are required to make regular payments and will forfeit the non-insured discount if they fail to make all required payments due under the payment plan.

Consent to HIV/HBV Testing

In the event a health care provider is directly exposed to my blood or body fluids, I consent to blood tests to determine the presence or absence of antibodies to the Human Immuno-Deficiency Virus (HIV) and the Hepatitis B Virus (HBV). I understand that the test results will become a permanent part of my health care record. The test results may be released to me or my legally authorized representative and the person who was exposed. In addition, the test results can be obtained by my health insurance carrier or by any person or entity to whom I have given written permission for access to my medical record. In certain circumstances your records could be subpoenaed for a court order.

Lab Specimens

Any lab specimens processed by an outside reference lab will be billed for by those reference labs. Your insurance company dictates which reference lab we may use—if you do not update us on your current insurance coverage, your specimens may end up at an inappropriate lab, resulting in fees which you will be liable. Any concerns regarding your insurance coverage and/or itemized statements received, should be directed to the billing department of the outside reference lab.

Acknowledgment of Policies

I/We assign to Blue Ridge Orthopaedic & Spine Center all monies entitled to me for the purpose of payment of any unpaid balance resulting from medical treatment received at this facility. I/We further understand that I/We are solely, or together, financially responsible for all charges incurred at this facility but not covered by this assignment, even though represented by an attorney.

Patient/Guarantor's Signature _____ Date _____

Patient Name: _____ Appointment Date: _____/_____/_____

Account #: _____

Review of Systems: Please check [√] any of the following symptoms you are having:

Constitutional	**Integumentary**	**Neurological**
☐ unexplained weight loss: _____lbs.	☐ rashes	☐ headache
☐ unexplained weight gain: _____lbs.	☐ frequent bruising	☐ blackouts and fainting
☐ night sweats	☐ hives	☐ tingling / numbness
☐ fevers/chills	☐ sores that don't heal	☐ paralysis
☐ loss of appetite	☐ NONE	☐ seizures
☐ NONE		☐ memory loss
		☐ NONE
Eyes	**Cardiovascular**	**Ear/Nose/Throat**
☐ blurry vision	☐ chest pain/pressure/tightness	☐ vertigo/dizziness
☐ double vision	☐ palpitations	☐ ringing in the ear
☐ eye pain	☐ trouble breathing while lying	☐ nose bleed
☐ NONE	☐ NONE	☐ sinusitis
		☐ trouble swallowing
		☐ hearing aid
		☐ NONE
Respiratory	**Psychological**	**Gastrointestinal**
☐ shortness of breath	☐ depression	☐ stomach pain/heart burn
☐ COPD	☐ anxiety	☐ bloody or dark stools
☐ chronic cough	☐ NONE	☐ constipation
☐ NONE		☐ diarrhea
		☐ nausea/vomiting
		☐ NONE
Musculoskeletal	**Genitourinary**	
☐ joint pain	☐ blood in the urine	
☐ joint redness and swelling	☐ painful urination	
☐ leg pain with walking	☐ urgency to urinate	
☐ muscle cramps	☐ loss of bladder control	
☐ weakness	☐ frequent urination	
☐ NONE	☐ difficulty urinating	
	☐ NONE	

I acknowledge, I have reviewed the above information and have completed the form to the best of my ability.

_____ _____

Patient Signature M.D. Signature

For Clinical Use only

Ht. _____ **Wt.** _____ **B/P** _____ **P** _____ **BMI:**_____

Patient Registration Form

Date:_____

Patient's Last Name:_____ First:_____Middle: _____Suffix:_____

Mailing Address: _____

City: _____State: _____Zip: _____

Physical Address (if different from mailing):_____

City: _____State: _____Zip: _____

Home Phone#:_____ Cell Phone#:_____

Work Phone#:_____Ext:_____

Email Address: _____

Patient Date of Birth:_____ Patient Sex: Male ☐ Female ☐

Patient Social Security #:_____

Person Responsible for Bill: _____Relationship to patient: _____

Responsible Party Date of Birth: _____Responsible Party Contact Phone#:_____

Emergency Contact Name: _____Emergency Contact Relationship: _____

Emergency Contact Phone #:_____

Pharmacy of choice and location:_____Phone Number:_____

Primary Care Provider (name & phone number):_____

Referring Physician (name & phone number):_____

Patient marital status S_____ M _____ D _____W _____

Language:_____Race:_____Ethnicity:_____Declined:_____

Patient Employer:_____ Retired:_____Unemployed/Homemaker:_____

Body part to be seen: Right or Left _____Date patients' injury/pain occurred:_____

Injury Related: Yes ☐ No ☐ **Work Related:** Yes ☐ No ☐

Primary Insurance:_____Policyholder:_____

Policyholder relationship to patient:_____Policyholder DOB: _____

Member ID#: _____ Group#: _____

Secondary Insurance:_____Policyholder:_____

Policyholder relationship to patient:_____Policyholder DOB: _____

Member ID#: _____ Group#: _____

If this is a Workers' Compensation injury: provide claim information to the front office staff

How did you hear about us? (Please circle one)

- PCP/Referring provider/Insurance
- Previous/Existing patient
- Coworker/Friend/Family
- Magazine/Newspaper
- Radio/Billboard
- Social Media/Website
- Community Event
- Hospital (please circle)
  - Fauquier
  - Novant Health UVA
  - Culpeper
  - Other