ESTABLISHED PATIENT PACKET

Personal Information*

Prefix: Mr./Mrs./Other:________Patient*:____Suffix: Jr./Sr./Other: _________
Last First Middle Initial

Previous Name:________________________________Preferred Name: ________________________________

Mailing Address*: ____
Street Address City State Zip

Home #:________________________Cell #:____________________________Work #:__________________________Ext: ___________

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP):______________________________Address:______________________________Phone #: ________________
First Last

Referring Provider:________________________________Address:___________________________________Phone #: ___________________
First Last

Date of Birth*:______________Sex*:____________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
mm/dd/yyyy

Social Security #:_______-_____-________Employer Name:__________________________________Occupation:___________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Email: ____

Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other: _______________________

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: ______________________________________

Language*: ☐ English ☐ Spanish ☐ Other: _____________________________________

Pharmacy Name*:________________________________Address:______________________________________Phone #:
Street Address City State Zip

Emergency Contact*

Name:____Relationship: ___________________________________
Last First

Address: ____
Street Address City State Zip

Home #:__________________________Work #:___________________________Cell #: _________________________

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name:_______________________________________Date of Birth:_________________Sex:_______Social Security #:_____-______- _____
Last First mm/dd/yyyy

Address: ____
Street Address City State Zip

Home #:________________________Cell #:_____________________________Work #:__________________________Ext: ___________

Primary Insurance Information*

Insurance Name:___________________________Member ID #:_________________________Relationship to Insured:___________________

Employer:_____________________________________Group #:__________________________Effective Date: ____________________
mm/dd/yyyy

Insured's Information* - (if not self)

Name:_______________________________________Date of Birth:_________________Sex:_______Social Security #:______-______- _____
Last First mm/dd/yyyy

Relationship to Insured:________________________________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: ____
Street Address City State Zip

Home #:__________________________Work #:___________________________Cell #: _________________________

Secondary Insurance Information

Insurance Name:___________________________Member ID #:_________________________Relationship to Insured:___________________

Group#:___________________________________Effective Date: _______________________

Secondary Insured's Information - (if not self)

Name:_______________________________________Date of Birth:_________________Sex:_______Social Security #:______-______- _____
Last First mm/dd/yyyy

Relationship to Insured:________________________________Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐
Divorced Address: ____
Street Address City State Zip

Home #:__________________________Work #:___________________________Cell #: _________________________

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. **X____________________ (Please initial)**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X____________________ (Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X__________(Please initial)**

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents

X_______ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out

X______ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X__________(Please initial)**

____ ________________

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

____

Relationship (if any)

PHYSICAL THERAPY MEDICAL SCREENING QUESTIONAIRE

Name:____Date of Birth:________________ Age: ________

Are you latex sensitive? ☐ YES ☐ NO   Do you smoke? ☐ YES ☐ NO

Do you have a pacemaker? ☐ YES ☐ NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ YES ☐ NO

List any **drug allergies or contrast/dye allergies:** ____

Have you RECENTLY noted any of the following? (Check all that apply.)

- ☐ fatigue
- ☐ numbness/tingling
- ☐ constipation
- ☐ fever/chills/sweats
- ☐ muscle weakness
- ☐ diarrhea
- ☐ nausea/vomiting
- ☐ dizziness/lightheadedness
- ☐ shortness of breath
- ☐ weight loss/gain
- ☐ heartburn/indigestion
- ☐ fainting
- ☐ difficulty maintaining balance while walking
- ☐ difficulty swallowing
- ☐ cough
- ☐ falls
- ☐ changes in bowel/bladder function
- ☐ headaches

Have you EVER been diagnosed with any of the following conditions? (Check all that apply.)

- ☐ cancer
- ☐ depression
- ☐ thyroid problems
- ☐ heart problems
- ☐ lung problems
- ☐ diabetes
- ☐ chest pain/angina
- ☐ tuberculosis
- ☐ osteoporosis
- ☐ high blood pressure
- ☐ asthma
- ☐ pneumonia
- ☐ multiple sclerosis
- ☐ circulation problems
- ☐ rheumatoid arthritis
- ☐ epilepsy
- ☐ blood clots
- ☐ other arthritic condition
- ☐ eye problem/infection
- ☐ stroke
- ☐ bladder/urinary tract infection
- ☐ ulcers
- ☐ anemia
- ☐ kidney problem/infection
- ☐ liver problems
- ☐ bone or joint infection
- ☐ hepatitis
- ☐ sexually transmitted disease/HIV
- ☐ chemical dependency (i.e. alcoholism)
- ☐ pelvic inflammatory disease

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of following conditions? (Check all that apply.)

- ☐ cancer
- ☐ diabetes
- ☐ tuberculosis
- ☐ heart problems
- ☐ stroke
- ☐ thyroid problems
- ☐ depression
- ☐ high blood pressure

During the past month have you been feeling down, depressed or hopeless? ☐ YES ☐ NO

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ YES ☐ NO

If yes to either, is this something with which you would like help? ☐ YES ☐ YES, but NOT today ☐ NO

Please list any medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

____

____

Have you ever taken steroid medications for any medical conditions? ☐ YES ☐ NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ YES ☐ NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
____
____

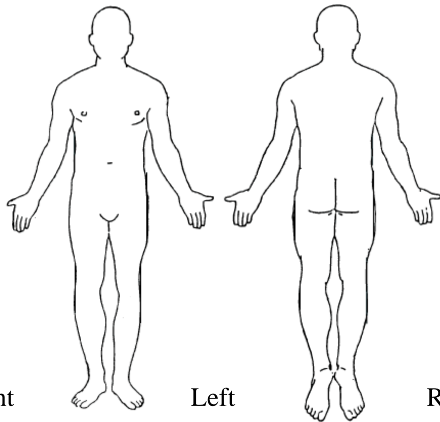
What date (roughly) did your present problem start? ____

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

Treatment received so far for this problem (i.e. chiropractic, injections, surgery): ___________________________

Please list special tests performed for this problem (i.e. x-ray, MRI, labs): _______________________________

Body Chart: Please mark the areas where you feel symptoms on the chart with the following symbols to describe your symptoms: ↓ Shooting/sharp pain ○ Dull/aching pain ||| Numbness = Tingling



My symptoms currently:

☐ Come and go

☐ Are constant

☐ Are constant, but change with activity

Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst paint imaginable"*, please describe:

Check mark your current level of pain while completing this survey: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Check mark the best your pain has been during the past 24 hours: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Check mark the worst your pain has been during the past 24 hours: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Easing Factors: Identify up to 3 important positions or activities that make your symptoms *better*:
1. ____
2. ____
3. ____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a results of your problem.
1. ____
2. ____
3. ____

How are you currently able to sleep at night due to your symptoms?
☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity
When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

Patient Name: ______________________________**Patient Signature:** ______________________________