NORTHERN VIRGINIA CENTER FOR ARTHRITIS

PLEASE PRINT

PATIENT REGISTRATION

Patient's Name:_____**DOB:**_____**Sex:**_____

Address:_____

_____

PLEASE CHECK THE BOX AFTER THE PHONE NUMBER THAT YOU WANT AS YOUR PREFERRED NUMBER

Home#( )_____[__]__**Cell#( )**_____[__]__**Work#( )**_____[__]_

Race:_____**Ethnicity:**_____**Preferred Language:**_____

Name of Primary Care Physician:_____**Phone#**_____

Name of Referring Physician:_____**Phone#**_____

Employer:_____

Employer's Address:_____

Marital Status:_____**Spouse's Name:**_____

Spouse's DOB:_____**Spouse's Phone#**_____

Emergency Contact's Name:_____**Phone#**_____

HEALTH INSURANCE COVERAGE: (To be completed by all patient-please note: WE DO NOT ACCEPT MEDICAID)

Primary Health Insurance Company Name:_____

Address:_____

ID#_____**Group#**_____

Subscriber's Name:_____**DOB:**_____**Relationship to Patient:**_____

Secondary Health Insurance Company Name:_____

Address:_____

ID#_____**Group#**_____

Subscriber's Name:_____**DOB:**_____**Relationship to Patient:**_____

REVERIFIED INFORMATION

Patient's Signature:_____**Date:**_____

NORTHERN VIRGINIA CENTER FOR ARTHRITIS

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PATIENT REGISTRATION

CURRENT MEDICATIONS

Name of Medication: **Strength:** **Directions:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

PHARMACY INFORMATION

Name of Local Pharmacy:_____**Phone#**_____

City:_____**State:**_____**Zip Code:**_____

Name of Specialty Pharmacy:_____**Phone#**_____

Address:_____

_____

ID#_____**Group#**_____

Medication Allergies:_____

NORTHERN VIRGINIA CENTER FOR ARTHRITIS

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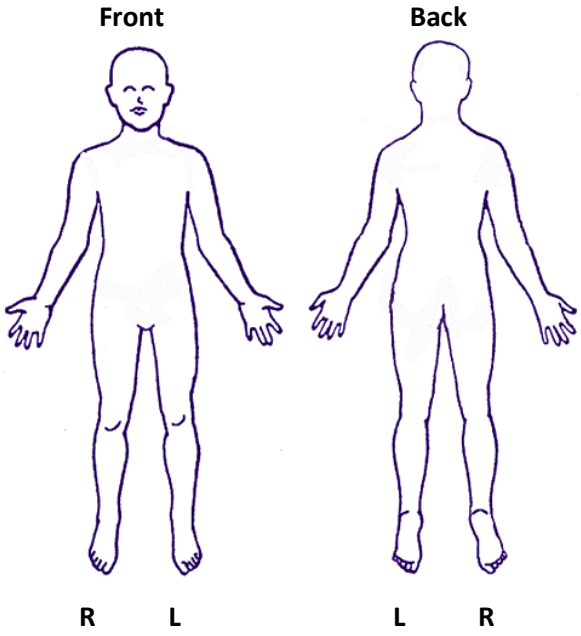
PATIENT QUESTIONNAIRE

Patient's Name:_____**Date:**_____

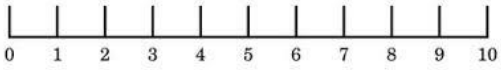
Chief Complaint-(reason for visit):_____

On the diagram below, mark the areas where you feel pain:



Pain level today-(circle number)

Stiffness level today-(circle number)



Your pain occurs: [ ] intermittent [ ] continuous [ ] occasional [ ] rare

Describe your pain: [ ] throbbing [ ] dull [ ] aching [ ] shooting [ ] stabbing [ ] burning

Is your pain: [ ] mild [ ] moderate [ ] severe [ ] unbearable

The pain has been occurring for:_____ **[ ] days [ ] weeks [ ] months [ ] years**

I have morning stiffness that lasts for:_____ **[ ] minutes [ ] hours**

I have tried the following medications for this problem in the past:_____

_____

<u>Past Surgical History</u> – (please list all surgeries with year they were preformed):_____

_____

_____

NORTHERN VIRGINIA CENTER FOR ARTHRITIS

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PATIENT QUESTIONNAIRE

Past Medical History: - (Please check all that apply)

[ ] Headaches [ ] High blood pressure [ ] High cholesterol [ ] Heart disease [ ] Diabetes [ ] Cancer [ ] Arthritis

[ ] Stroke [ ] Thyroid disease [ ] Peripheral vascular disease [ ] Neurological disease [ ] Stomach ulcers

[ ] Hepatitis [ ] Asthma [ ] Depression [ ] Anxiety [ ] Lupus [ ] Anemia [ ] Glaucoma [ ] Lyme's disease

[ ] Gout [ ] Psoriasis [ ] Kidney disease [ ] HIV

Family History: -(Please check all that apply for each family member)

	Mother	Father	Sister	Brother	Other Family
Arthritis	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety/Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]
Gout	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Lupus	[ ]	[ ]	[ ]	[ ]	[ ]
Neurological Disorders	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoporosis/Osteopenia	[ ]	[ ]	[ ]	[ ]	[ ]
Psoriasis	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Vasculitis	[ ]	[ ]	[ ]	[ ]	[ ]

Social History:

Tobacco Use: [ ] Yes [ ] No _____per day

Alcohol Use: [ ] Yes [ ] No [ ] Socially [ ] Daily [ ] Weekly

Do you have problems with Drug or Alcohol use or dependency? [ ] Yes [ ] No

The above information is accurate to the best of my knowledge.

Patient's Signature:_____Date:_____

NORTHERN VIRGINIA CENTER FOR ARTHRITIS, P.C.

PATIENT AUTHORIZATION AND ASSIGNMENT

I,_____, hereby authorize Northern Virginia Center for Arthritis, P.C. to apply for benefits on my behalf for services rendered. I request that payment be made directly to Northern Virginia Center for Arthritis, P.C. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any medical or other information for this or any related claims to my insurance companies. I permit a copy of this authorization and assignment to be used in place of the original. This will remain in effect until revoked be me in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fees. I also understand that failure to provide Northern Virginia Center for Arthritis with new insurance information that I may have within a timely manner will result in my personal financial responsibility.

_____ _____

Patient or Guardian's Signature **Date**

NORTHERN VIRGINIA CENTER FOR ARTHRITIS, P.C.

PRIVACY POLICIES

Please sign below that you were offered a copy of our privacy policy notice.

_____

Patient's Name-(please print)

_____

Patient's Signature **Date**

[ ] Please check the box if you give Northern Virginia Center for Arthritis permission to share your protected health information with other health care professionals.

[ ] Please check the box if you give Northern Virginia Center for Arthritis permission to leave messages on your answering machine regarding appointments, test results or other protected health information.

[ ] Please check the box if you give Northern Virginia Center for Arthritis permission to mail test results or other protected health information to you upon request.

My protected health information may be shared with the following peron(s):

_____

_____

_____

_____

Privacy Officer's contact information

(703) 689-2050

NORTHERN VIRGINIA CENTER FOR ARTHRITIS, P.C.

OFFICE POLICES

1. **We require 24 hour notification if you need to cancel your appointment. We reserve the right to charge a $50.00 charge for new patient and a $25.00 charge for established patients. Please make sure you update your phone numbers with the receptionist to receive your reminder call.**
2. **All co-pays and balances must be paid and up to date before being seen by the physician. Insurance coverage is the patient's responsibility and any discrepancies or questions should be directed to the insurance company.**
3. **For all patients with HMO insurance policies, you must present your referral to the receptionist upon signing in. If you do not have your referral, you will be asked to reschedule your appointment. We have a contract with the insurance companies and are not allowed to see the patient without the referral. We ask that you hand carry your referral. It is the responsibility of the patient to obtain their referral-NOT OUR OFFICE.**
4. **All prescriptions for narcotics must be picked up and signed for. We can no longer mail these prescriptions. If someone other than yourself is picking up the prescription, they must have a SIGNED letter from you and a photo ID.**
5. **Labs, x-ray reports and non-narcotic prescriptions may be picked up. Please give us advanced notice so that we can have them ready for you.**
6. **If you require copies of your medical records a $10.00 initial charge and .10 cents/page will apply.**
7. **There will be a charge for any forms that need to be filled out by the physician, this includes but not limited to medical leave forms, long term care insurance or any insurance forms. The charge will depend upon the complexity of the forms. Please note: we do not fill out functionality or disability forms. We will send medical records.**
8. **We do not fax or call to mail order pharmacies. If you use mail order pharmacies, you can come and pick up the prescription or get it at the time of your appointment. If you use a local pharmacy and need a refill, please have your local pharmacy fax the request to our office. Please allow 24-48 hours for the request to be returned to the pharmacy.**
9. **Any inappropriate behavior in the office may lead to you being dismissed from our practice.**

Thank you for your understanding.

Patient's Name Printed:_____

Patient Signature:_____Date:_____