TYSONS INTERNAL MEDICINE AND WELLNESS CENTER

PATIENT INFORMATION

First Name: _____ Last Name: _____ Sex: M ( ) F ( )

Address:_____ City:_____ State:_____ Zip:_____

Home phone: _____ Cell: _____ Email _____

DOB: Month_____ Day____ Year _____ Race: _____ Marital Status: _____

Employer _____ Address _____

Phone _____ Occupation _____ Education _____

EMERGENCY CONTACT:

First Name:_____ Last Name: _____ Relationship to patient: _____

Home phone: _____ Cell phone: _____

INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder: _____

Member ID: _____ Group number: _____

PREFERRED PHARMACY:

Name: _____ Phone: _____

Address: _____

1. Tysons Internal Medicine and Wellness Center does not guarantee insurance coverage as payment.
2. If your insurance company does not settle your claim within 90 days of claim submission, then you will be billed for the services.
3. All non-covered services need to be paid at time of visit.
4. All co-payments need to be paid at the time of the visit.
5. There will be **a $50 charge** for any missed appointment without **24 hour cancellation notice.**

Signature _____ Date _____

PAST MEDICAL HISTORY (Please check all that apply)

( )Abnormal Mammogram	( ) Cancer	( ) Heart Disease	( ) Mental Illness _____
( ) Abnormal Menstruation	( ) Chronic Headache	( ) Hernia	( ) Prostate Disease
( ) Abnormal Pap Smear	( ) Circulation Problem	( ) High Blood Pressure	( ) Rheumatoid Arthritis
( ) Abnormal T.B. test	( ) Colon Polyp	( ) High Cholesterol	( ) Seizure or Epilepsy
( ) Acid reflux	( ) Depression	( ) Hemorrhoids	( ) Sexually Transmitted Disease
( ) Active Tuberculosis (T.B.	( ) Diabetes	( ) HIV or AIDS	( ) Skin disease _____
( ) Allergies/Hay Fever	( ) Diverticulosis	( ) Intravenous Drug Use	( ) Stomach Ulcer
( ) Anemia	( ) Dialysis	( ) Liver Disease/Hepatiti	( ) Stroke
( ) Asthma	( ) Eating Disorder	( ) Lung Disease	( ) Thyroid Disease
( ) Blood Product Transfusion	( ) Gall Bladder Disease	( ) Lupus	( ) Other_____

FAMILY HISTORY: (Please check all that apply and indicate relationship to family member)

( ) Asthma	( ) Depression	( ) High Cholesterol	( ) Prostate Cancer	( ) Tuberculosis
( ) Bleeding Disorder	( ) Diabetes	( ) Mental Illness	( ) Skin Cancer	( ) Thyroid Disease
( ) Breast Cancer	( ) Heart Attack	( ) Osteoporosis	( ) Stroke	( ) Ovarian Cancer
( ) Colon/Rectal Cancer		( ) High Blood Pressure		( ) Other _____

MEDICATIONS: List current medications and doses (incl. birth control or shots, non- prescription drugs, vitamins, supplements, ointments, creams, nasal sprays, inhalers and eye drops_____

_____

_____

HOSPITALIZATIONS /MAJOR EVENTS _____

_____

_____

ALLERGIES to any medications (please list): _____

Allergic to: ( ) Latex ( ) Iodine/Dye ( ) Metal ( ) Food Allergies _____

PREVENTIVE CARE: Check and date all that apply: ( ) Mammogram _____ ( ) Pap Smear _____

( ) DEXA Scan _____ ( ) Colonoscopy _____ ( ) Physical _____

( ) Last Dental Exam _____ ( ) Last Eye Exam _____

IMMUNIZATIONS: (Check if you had the disease or received the vaccine and list the year)

( ) Diptheria/Tetanus _____
( ) Hepatitis A _____
( ) Hepatitis B _____
( ) Gardisil (HPV Vaccine) _____
( ) Influenza _____
( ) Measles/Mumps German Measles _____
( ) Meningitis _____
( ) Pneumonia _____
( ) Polio _____
( ) Small Pox _____
( ) T.B.Skin Test _____
Result: Positive/negative
Treatment: _____
( ) Zostavax _____

Concerns/ Comments:

Patient Signature: _____ **Date:** _____

☐ **I acknowledge that this history is correct and complete.**

SOCIAL HISTORY

Marital Status: _____ Children: _____ Occupation _____

Smoking Status ( ) Never smoked ( ) Now smoking ( ) Used to smoke ( ) Chew Tobacco

If smoking _____ cigarettes/packs per day/week

Alcohol type _____ Amount _____ per day/week

Street drugs including marijuana, cocaine, heroin and other mood altering drugs or pills _____

Caffeinated beverages (coffee, tea, soda, etc.) _____ per day/week Guns in the home? ( ) Y ( ) N

Do you consistently wear seatbelts? ( ) Y ( ) N

Sexual orientation ( ) Heterosexual ( ) Homosexual ( ) Bisexual ( ) Other

Do you eat well? _____ How do you feel about your weight? _____

Exercise type _____ How often? _____

Are you an organ donor? ( ) Y ( ) N Do you have a living will? ( ) Y ( ) N

FEMALES ONLY

Menstruation: Age of onset _____ Flow: ( ) regular ( ) irregular ( )heavy ( ) moderate ( ) light

Number of pregnancies _____ Last Pap Smear ( ) normal ( ) abnormal

Number of live births _____ Last Mammogram ( ) normal ( ) abnormal

Number of abortions _____ Number of ectopic pregnancies _____

Number of miscarriages _____ Age at first pregnancy _____

Are you currently pregnant? ( ) Y ( ) N Are you breastfeeding? ( ) Y ( ) N

Any post-menopausal vaginal bleeding? ( ) Y ( ) N

MALES ONLY

Do you practice testicular self- exam? ( ) Y ( ) N Do you have urinary frequency? ( ) Y ( ) N

Is there a history of impotence? ( ) Y ( ) N Do you awaken at night to urinate? ( ) Y ( ) N

Do you have a urethral (penile) discharge? ( ) Y ( ) N Do you regularly use condoms? ( ) Y ( ) N

HEIGHT _____ WEIGHT _____

Tysons Internal Medicine

FINANCIAL POLICIES, EFFECTIVE 01/01/2019

Private Pay: If you do not have insurance, payment will be due at the time of service. We require a minimum of 100% of the balance paid at the time of service.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that Dr. Lorena Popp participates in your specific plan. If Dr. Lorena Popp is not a participating provider for your plan, you may still select our office for your medical care: "out of network" benefits will apply. It is also your responsibility to know your insurance benefits. Our office will not advise you of your benefits. Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to coverage.

As a courtesy to our patients, we file claims to your insurance on your behalf. In order to do this, we require all information to be completes on the Patient Registration Form. You will be asked to show your insurance card at each visit.

You are responsible for paying all co-pays at the time of service. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on your insurance carrier.

Billing: If you receive an invoice from our office for balance due, it is because that is the balance your insurance policy requires you to pay. Please contact your insurance company first if you have a problem.

A NO SHOW FEE OF $50.00 WILL BE CHARGED, IF YOUR APPOINTMENT IS NOT CANCENCELLED 48 HOURS IN ADVANCE.

We require a credit card on file to pay for co-pays, missed appointment fees, and any balance reported as patient responsibility. You will be notified of any charges equal to or more than $100.00.

PATIENT NAME: _____

CREDIT CARD #: _____ EXP: _____

CVV CODE: _____

BY PROVIDING A CREDIT CARD ON FILE, YOU ARE AUTHORIZING TYSONS INTERNAL MEDICINE TO CHARGE YOUR CREDIT CARD FOR ANY MISSED APPOINTMENT FEE OR BALANCE ON YOUR FILE.

Welcome to:

Tysons Internal Medicine & Wellness Center

Office Policy

If you are unable to keep your appointment, please let us know within:

24 hours in **advance** for **medical** and **48 hours** in **advance** for **cosmetic patients.**

Otherwise patient will be responsible for a **cancellation fee** of :

$50.00 for medical appointment

$150.00 for cosmetic appointment

Office requires all pending balances to be clear at time of your visit.

Patient's signature _____

Date_____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

☐ - Spouse _____

☐ - Child(ren) _____

☐ - Other _____

☐ - Information is not to be released to anyone other than me.

Messages

Please call ☐ my home phone is _____ ☐ my cell phone is _____

If unable to reach me:

☐ - You may leave a detailed message

OR

☐ - Please leave a message asking me to return your call

☐ - Do not leave messages on my phone mailbox.

The best time to reach me is (day of week)_____ between (time)_____

E-mail Messages

☐ - Use my e-mail address to send messages for me to contact the nurse for information OR
☐ - Use my e-mail to leave detailed messages and information.

☐ Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature:_____ Date: ____/____/____

Form Made Fillable by AuthorizationForms.com