PATIENT DEMOGRAPHIC

LAST: FIRST: MIDDLE:

SOCIAL SECURITY # . DATE OF BIRTH: GENDER: (CIRCLE) *MALE* *FEMALE*

MARITAL STATUS: (CIRCLE) *DIVORCED* *MARRIED* *SEPERATED* *SINGLE* *WIDOWED*

STUDENT STATUS: (CIRCLE) *FULL TIME* *PART TIME* *NOT A STUDENT*

ADDRESS:

CITY: STATE: ZIP:

HOME #: CELL #: WORK #:

EMPLOYER NAME:

EMPLOYER ADDRESS:

CITY: STATE: ZIP:

EMPLOYER PHONE NUMBER:

EMPLOYEMENT STATUS: (CIRCLE) *FULL TIME* *PART TIME* *RETIRED*

SELF EMPLOYED *NOT EMPLOYED*

SPOUSE EMPLOYER NAME:

SPOUSE EMPLOYER ADDRESS:

CITY: STATE: ZIP:

SPOUSE EMPLOYER PHONE NUMBER:

RACE: (CIRCLE) *AMERICAN INDIAN/ALASKAN* *ASIAN/PACIFIC ISLANDER* *BLACK/AFRICAN AMERICAN*

HISPANIC *UNKNOWN* *WHITE/CAUCASION* *OTHER*

PATIENT DEMOGRAPHIC - CONTINUED

ETHNIC: (CIRCLE) *CAUCASION/WHITE* *HISPANIC/LATINO/BLACK* *HISPANIC/LATINO* *NON HISPANIC* *UNKOWN*

PRIMARY LANGUAGE:

EMAIL ADDRESS:

PRIMARY PHYSICIAN NAME:

PRIMARY PHYSICIAN ADDRESS:

CITY: **STATE:** **ZIP:**

PRIMARY PHYSICIAN PHONE #:

REFERRING PHYSICIAN NAME:

REFERRING PHYSICIAN ADDRESS:

CITY: **STATE:** **ZIP:**

REFERRING PHYSICIAN PHONE #:

HOW DID YOU HEAR ABOUT US? (CIRCLE) *EMPLOYER* *INSURANCE* *INTERNET* *LAP-BAND* *LOCATE-A-DOC*

MAGAZINE *NEWSPAPER* *PHYSICIAN REFERRAL* *RADIO* *REALIZE-BAND* *TV*

VH WEBSITE *WORD OF MOUTH*_____ *OTHER*_____

EMERGENCY CONTACT NAME:

EMERGENCY CONTACT RELATIONSHIP:

EMERGENCY CONTACT PHONE #:

PRIMARY INSURANCE:

SECONDARY INSURANCE:

TERTIARY:

CURRENT/ACTIVE MEDICATIONS
(If available attach medications list

DATE ORDERED		DATE DISCOUNTINUED	PRESCRIBER	MEDICATION NAME	DOSAGE	WHY IS PATIENT TAKING THE MED?	HOW OFTEN IS THE MED TAKEN

ALLERGIES

ALLERGIES	REACTION	DATE DOCUMENTED

SURGERIES/PROCEDURES

SURGERY PERFOMED	DATE OF SURGERY	PERFORMING PHYSICIAN

SUBSTANCE ABUSE

	YES	NO	# OF YEARS	WHEN DID YOU QUIT
ALCOHOL				
CIGARETTE				
CIGARETTE				
PIPE				
ORAL/SNUFF				
DRUG USE				

PERSONAL & FAMILY HISTORY

Check any of the following that apply to you/your family and explain in detail in the remarks section with date and treatments.

	YOU	FAMILY		YOU	FAMILY
AIDS/HIV			Anesthesia Problems		
Atril Fibrillation			Breast Cancer		
Alcoholism			lung Cancer		
Angina			Colon Cancer		
Heart Attack			Prostate Cancer		
Stroke			Other Cancer		
Heart disease			Bleeding Problems		
High Lipids			Artheritis		
High BP			Mental Illness		
High Cholesterol			Rediation Therapy		
Coumadin Therapy			Emphysema		
Mitral Valve Prolapse			Hepatitis		
Colitis			Pacemaker Implant		
Diabetes			Asthma		
Kidney Disease			Seizure Disorder		
Thyroid Disease			Chemotherapy		
TB					

REMARKS

PATIENT NOTIFICATION RECEIPT AND ACCESS TO PATIENT CARE

Patient's Name: _____ Today's Date: _____

Patient's Date of Birth: _____

PATIENT NOTIFICATION RECEIPT

I understand that as a part of my healthcare, Valley Physician Enterprise originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning and carrying out medical care and treatment; a means of communication among the many health professionals who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third party payers can verify that services were actually provided; and a tool for routine health care operations such as quality assurance, audits and assessments.

ACCESS TO PATIENT CARE

I hereby give permission to the person(s) listed to inquire about information regarding mine/my child's medical care.

Name	Relationship	Name	Relationship
1.		2.	
3.		4.	

MINORS

As a parent, I understand that there will be situations where others will be responsible for the care and well-being of my child. If, during those times, my child requires medical attention and /or transportation to an appointment, the following temporary caregivers listed are, authorized for such situations. The persons listed will be requested to provide two personal identifiers of the parents or guardians, which are normally, date of birth and the last four digits of the social security number. If the information cannot be provided, treatment may be delayed or the appointment rescheduled.

In Addition:

I authorize Valley Physician Enterprise to call my home or other designated location and leave a non-specific message on my voicemail, contact me in person or by mail. I may revoke this authorization in writing at any time.
For specific information, I am aware that I will need to complete the Consent to Release Protected Health Information form, prior to information being released, as specified in the VPE HIPAA Notice of Information Practices.

Print Name: _____ Signature: _____

I understand that this form is valid for 1 year from the date that I sign it and it applies to all VPE practices.

VPE

AGREEMENT AND CONSENT TO TREATMENT, RELEASE OF INFORMATION, INSURANCE ASSIGNMENT, AND PAYMENT OF CHARGES

VPE for the purposes of this Agreement and Consent, includes all practices providing healthcare services which are part of Valley Physician Enterprise

Medical and Clinical Consent:

I request treatment from VPE and consent to all: diagnostic evaluations, surgical procedures, therapy services, diagnostic tests, medications and/or treatments that are ordered or performed by my attending physician, his or her associates, consultants, assistants, or designees, or other independent medical service providers as are advisable or necessary in my physician's judgment. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion or handicap.

Release of Information:

I authorize VPE and any physician or other medical service provider who renders service to me to release to my physician and other health care providers treating me, insurance company, reimbursing agency, affiliated entities, attorneys and other as allowed by law; whatever information, including a copy of, or access to, my medical record for determination of benefits payable or for additional medical care. Further, I authorize the social Security Administration to release any information regarding my benefits or Medicare eligibility to any health care provider or other independent medical care provider.

Medicare Beneficiary:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about to release to the Social Security Administration or its agents any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Right to Decide:

I understand that I have the right to make decisions about my care. I have the right to refuse or accept treatment. I have the right to have a "Living Will", Advance Directive or to designate someone to make decisions for me by using a "Durable Power of Attorney for Health Care".

Notice of Deemed Consent to HIV Blood Testing:

A law was enacted in Virginia in 1989 and amended in 1993 which authorizes healthcare providers to test their patients for HIV, Hepatitis B and C antibodies when the healthcare provider is exposed to the body fluids of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to the release of the test results to the healthcare provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained, and you will be given the opportunity to ask any questions.

Financial Agreement:

I authorize payment of all medical benefits otherwise payable to me directly to VPE. I understand that I am responsible for all health insurance deductibles and coinsurance. I understand that if my insurance company has a precertification requirement that it is my responsibility to obtain this pre-certification. The benefits of Homestead Exemption are waived as to any debt created incident to this account for the services covered by this Consent Form. I understand that I remain financially responsible to VPE for any and all charges not met by the proceeds of this assignment, and for all charges if payment is not received within a reasonable time after charges are filed or if payment is deemed retroactively. I accept responsibility for payment in full, or agreed upon payment arrangements, for services provided within thirty (30) days of receiving a statement. In the event I do not meet my financial responsibility with VPE, I agree to pay costs for collection including the collection agencies fees 20% to 40%, interest, court costs, and attorney fees up to the maximum of the Commonwealth of Virginia Statute.

I have been given or offered a copy of the Notice of Privacy Practices, version effective February 17, 2010.

I have read this form or have had it read to me, and it has been explained to my satisfaction. I understand that this form is valid for one (1) year from the date that I sign it and applies to all VPE practices.

Patient Name (Print) _____ Patient or Responsible Party Signature _____ Date _____

Responsible Party's Relationship to Patient _____ Responsible Party's Address _____

I witnessed the signature: _____ Employee Signature _____ Title _____ Date _____