

ARLINGTON WOMEN'S CENTER, PLLC

(For office use only)

Primary Ins.: _____

Secondary Ins.: _____

LAB:

LABCORP (we bill) _____

LABCORP (lab bills) _____

QUEST (lab bills) _____

PATIENT INFORMATION (PLEASE PRINT)

Today's date: _____ Date of birth: _____ Age: _____

Patient Name: _____

How would you like to be addressed? (Nickname): _____

Social Security #: _____ - _____ - _____ Maiden name/other name used: _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Other

Home address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

I Prefer that you Call me at (circle) Home Work Cell

I authorize this practice to leave messages regarding my medical appointments, conditions, test results, with:

Household Family Members	Yes	No	Cell Phone	Yes	No
Answering Machine Home	Yes	No	Answering Machine Work	Yes	No

Your place of employment: _____ Occupation: _____

Emergency Contact Person: _____ Emergency Phone: _____

SPOUSE AND RESPONSIBLE PARTY INFORMATION

Name of Spouse or responsible party (if other than yourself) _____

Employer Name: _____ Occupation: _____

Work phone: _____ x _____ Responsible Party Social Security #: _____ - _____ - _____

INSURANCE INFORMATION

Primary Insurance Co.: _____ Group # _____ ID # _____

Policy Holder Name: _____

Policy Holder Social Security #: _____ - _____ - _____ Policy holder date of birth: _____

Your relationship to Policy holder: ___ Self ___ Spouse ___ Parent ___ Other (specify) _____

Secondary Insurance Co.: _____ Policy Holder Name: _____

Policy Holder Social Security #: _____ - _____ - _____ Policy holder date of birth: _____

Patient Identification Number: _____

AWCDEMOGRAPHICFORM 12/08

PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Birthdate:** ____/____/____ Today's Date: ____/____/____

Name of Primary Care Physician: _____ Who referred you? _____

Reason for visit: _____ **DRUG ALLERGIES:** _____

Number of Pregnancies: _____ Number of Children Born: _____

**Have you or anyone in your family (Mom, Dad, siblings, grandparents) had the following:
(Use MGM for maternal grandmother, PGF for paternal grandfather, etc.)**

	SELF	OTHER FAMILY MEMBERS	
Alzheimer's			What surgeries have you had?
Asthma			
Birth Defects			
Bleeding Disorders			
Blood Clot History			
Breast Cancer			
Other Cancer			
Diabetes			
Epilepsy			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Twins			

Please Circle any of the following YOU have had:

- | | | | |
|---------------------|-------------------|--------------------------------|--------------------------|
| Anemia | Hepatitis (A/B/C) | Mitral Valve Prolapse | -Human Papilloma Virus |
| Blood Transfusion | High Cholesterol | Sexually Transmitted Diseases: | -Syphilis |
| Bowel Problems | Kidney Stones | -Chlamydia | Substance Abuse |
| Depression | Lung Disease | -Genital Warts | Thyroid Disease |
| Fibromyalgia | Lupus | -Gonorrhea | Ulcers |
| Gallbladder Disease | Migraines | -Herpes | Urinary Tract Infections |

How old were you when you had your first menstrual cycle? _____
 Are your menstrual cycles regular? Y N How many days apart are they? _____ Duration? _____
 Are they heavy? Y N Severe cramping? Y N
 When was the first day of your last menstrual cycle? _____
 When was your last Pap smear? _____
 Have you ever had an abnormal Pap smear? Y N When? _____ How was it treated? _____
 When was your last mammogram? _____
 Have you ever had intercourse? Y N
 How many sexual partners have you had in the last 6 months? _____
 Are you sexually active with men? Y N women? Y N or both? Y N
 What method of contraception do you or your partner use? _____
 Has your partner had a vasectomy? Y N
 Do you smoke cigarettes? Y N How many per day? _____
 How many servings do you consume each week of: Beer _____ Wine _____ Hard Liquor _____
 How many servings of caffeine do you consume each day? _____
 What vitamins/herbal supplements do you take regularly? _____

Please list the name, dosage and dosing schedule of any medication you currently take:

Please list your pharmacy name and phone number: _____

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

Provider's Signature: _____ **Date:** _____

ARLINGTON WOMEN'S CENTER, PLLC
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**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

With my consent, ARLINGTON WOMEN'S CENTER, PLLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ARLINGTON WOMEN'S CENTER, PLLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, ARLINGTON WOMEN'S CENTER, PLLC, may mail to my home any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to ARLINGTON WOMEN'S CENTER, PLLC use and disclosure of my Protected Health Information to carry out Treatment, Payment and healthcare Operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ARLINGTON WOMEN'S CENTER, PLLC may decline to provide treatment to me.

FINANCIAL POLICIES

With my consent, ARLINGTON WOMEN'S CENTER, PLLC, may have additional testing performed on any abnormal test results (i.e., if your pap smear is abnormal, the lab must perform additional testing on the specimen). I understand that any additional testing will be billed directly to my insurance company or to me.

ARLINGTON WOMEN'S CENTER, PLLC, will charge my account a \$10 processing fee for prescription refills or replacing lost prescriptions. This process may involve filling out and faxing pharmacy or insurance forms. I understand that I will be given a prescription for any medications I require during my appointment at no charge. I also understand that the charge of \$10 only pertains to requests for additional processing of that prescription.

ARLINGTON WOMEN'S CENTER, PLLC will charge my account a \$30 no-show fee if I do not call to cancel my appointment at least 24 hours before my scheduled appointment time.

ARLINGTON WOMEN'S CENTER, PLLC will charge my account a \$15 fee in addition to my copay amount if I do not pay my copay at the time of my appointment.

ARLINGTON WOMEN'S CENTER, PLLC will charge my account a \$35 returned check fee for any check which is returned for any reason.

I authorize payment of medical benefits to ARLINGTON WOMEN'S CENTER, PLLC for services provided.

I agree to pay in full any balance for services that are deemed to be my responsibility. This may include services denied by my insurance as non-covered, applied to my deductible, part of my coinsurance, etc. If I fail to pay, I understand that my account may be sent to a collection agency and I may be discharged from the practice. I agree to be financially responsible for any collection fees incurred.

I understand that it is my responsibility to provide the office of ARLINGTON WOMEN'S CENTER, PLLC, with my current insurance card at the time services are rendered to me. I understand that if I provide incorrect or expired insurance information I will assume full financial responsibility for all charges incurred.

I have reviewed ARLINGTON WOMEN'S CENTER, PLLC's Notice of Privacy Practices and Financial Policies.

Signature of Patient or Legal Guardian

Patient's Printed Name

Date