**Valley Family Practice & Internal Medicine**

812 Amherst St. Suite 101

Winchester, VA 22601

Robert W. Duck M.D Meenu Gopal M.D. Kathryn Durbin PA-C Brittany DeHaven NP

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient Information***

Patient Name (last/first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph#: (\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Ph#: (\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Sex (M/F): \_\_\_\_\_ Employed (Y/N): \_\_\_ Student (FT/PT):\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone#: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to leave a detailed message on your answering machine? (Y/N) \_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insurance Information***

Primary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex (M/F)\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Policy Holder Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer/School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_Policy Holder Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Insurance Plan (Y/N): \_\_\_\_\_\_ Relationship of Patient to Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex (M/F)\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Policy Holder Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer/School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_Policy Holder Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Insurance Plan (Y/N): \_\_\_\_\_\_ Relationship of Patient to Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient and Responsible Party Authorization**

I authorize the physician(s) at Valley Family Practice for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) to apply for benefits on my behalf for the covered services rendered and request that payments from my insurance company be made directly to Valley Family Practice. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim to the above named agent. I permit a copy of this authorization in place of the original. In all cases, professional fees are the patient, spouse, guardian and/or parents’ responsibility. Finance Charge may be computed by a “periodic rate” of 1 ½ % per month, which is an Annual Percentage Rate of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party(ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees, as well as any interest that may be adjudicated for the collection of the past due debts.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Print Name Signature Date

**Electronic Medical Records (EMR)**

As of April 2006, Valley Family Practice implemented a community based electronic medical record system. This system will replace the existing paper based methodology of medical record keeping. The records will be in a centralized data base, accessible by all offices that are members of the Shenandoah Independent Practice Association (SIPA). However, only practices that are actually treating you are permitted to access your medical record. SIPA’s centralized database employees the latest security and data protection technology required by state and federal law to ensure that there is no unauthorized access to your records.

**HIPAA Statement**

I have read Valley Family Practice’s “Notice of Privacy Practices”, and I hereby authorize Valley Family Practice to furnish to my insurance company or authorized agent information regarding my protected health information for the purposes of treatment, payment, or health care operations. I further authorize the physicians of Valley Family Practice to consult as needed at their sole discretion with other medical providers regarding my medical care. I wish to place the following restrictions concerning the disclosure of my protected health information. Valley Family Practice can discuss my medical condition/information with the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* If you check “yes” in any of these boxes, please provide us with a name. \*\***

Spouse: Yes No Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child: Yes No Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents: Yes No Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friends: Yes No Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Patient Signature Signature Authorized Person Date

**Valley Family Practice**

New Patient Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_single \_\_married \_\_divorced \_\_widowed

**Indicate whether you or your family members (parents, grandparents, siblings) have had the following:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **You** | **Your Family** |  |
| Heart Disease | Y N | Y N |  |
| Stroke | Y N | Y N |  |
| Cancer | Y N | Y N | What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| High Cholesterol | Y N | Y N | Last time it was checked: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| High Blood Pressure | Y N | Y N |  |
| Ulcers or Reflux | Y N | Y N |  |
| Diabetes | Y N | Y N |  |

**List any other conditions you have:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any surgeries you have had (what type and when):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List the medications you take (both over-the-counter and prescribed)**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug Name | Dosage (mg) | How often/when | When started |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**List other doctors/providers (name and specialty)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any medication? Y N**

|  |  |
| --- | --- |
| Drug Name | What happens/type of reaction |
|  |  |
|  |  |
|  |  |

**Valley Family Practice**

**New Patient Questionnaire**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please circle Yes or No:** |  |  |  |  |
| 1. Do you have trouble with your vision? 2. Do you have trouble with hearing? 3. Do you have any trouble swallowing? 4. Do you ever have difficulty breathing? 5. Do you frequently have a cough? 6. Do you ever have chest pain or tightness? 7. Do you ever have palpitations or feel your heart racing? 8. Do you have trouble with indigestion? 9. Do you ever have abdominal pain? 10. Do you have trouble with diarrhea? 11. Have you ever had blood in your stool? 12. Have you had unexplained weight loss? 13. Do you have trouble with heartburn? 14. Do you ever have blood in your urine? 15. Do you ever have pain with urination?   **Female Only:**   1. How old were you when you had your first period? 2. Are your periods regular? 3. How many days do you bleed? 4. How many pads or tampons do you use on your heaviest day? 5. Do you ever miss school or work because of your period? 6. Are you sexually active? 7. If yes, do you or your partner use anything to prevent pregnancy? 8. If yes, what do you use? 9. Is your sexual activity satisfactory? 10. Do you leak urine with coughing or laughing? 11. Do you have trouble making it to the bathroom on time? 12. When was your last pap smear? 13. When was your last mammogram?   **Males Only:**   1. Are you sexually active? 2. Is your sexual function satisfactory? 3. Do you have trouble starting your urine flow? 4. Do you dribble urine or have poor flow? 5. Do you get up more than once a night to urinate? | Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No Yes No  Yes No  Yes No  Yes No  \_\_\_\_\_\_  Yes No  \_\_\_\_\_\_  \_\_\_\_\_\_  Yes No  Yes No  Yes No  \_\_\_\_\_\_  Yes No  Yes No  Yes No  \_\_\_\_\_\_  \_\_\_\_\_\_  Yes No  Yes No  Yes No  Yes No  Yes No |  | Do you smoke?  Have you ever smoked?  If no to both above, skip to the next section.  How much do you smoke?  For how long?  Do you have any interest in quitting?  Have you ever quite before?  Do you drink alcohol?  If no, please skip to the next section.  How often?  How many drinks?  Has your drinking ever caused a problem at work?  Do you ever feel guilty about your drinking?  Do you ever drink in the morning?  Have you ever been annoyed by people commenting on your drinking?  Have you ever thought you should cut back?  Do you ever feel sad, blue or down?  Do you have trouble sleeping?  Do you have trouble with your appetite?  Do you cry for no apparent reason?  Do you have trouble concentrating?  Do you feel guilty a lot of the time?  Have you withdrawn from activities you used to enjoy?  Have you had a decrease in your sex drive?  Have you ever thought of hurting yourself?  Are you being physically or emotionally abused by anyone in your household?  Office Use Only:  Reviewed \_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_ | Yes No Yes No  \_\_\_\_\_\_  \_\_\_\_\_\_  Yes No Yes No  Yes No  \_\_\_\_\_\_\_  \_\_\_\_\_\_\_  Yes No  Yes No Yes No  Yes No  Yes No  Yes No Yes No  Yes No Yes No Yes No Yes No  Yes No  Yes No  Yes No  Yes No |