Instructions for completing forms

Option 1:

Print blank forms and fill them by hand.

Option 2:

Fill forms on your computer.

The forms are fillable pdf forms and can be completed using a computer (Windows or Mac). **However**, the information you fill in **will not be saved unless you follow the instructions below.**

To safely save the information you fill in, you can either print the filled forms to paper or "**print to pdf"** (this will save an electronic copy of the filled form on your computer, which can then be printed to paper or emailed)**.** Most Windows and Mac computers have these "print to pdf" printers built in. See the instructions below:

Steps to Print to PDF in Windows:	Steps to Print to PDF on Mac:
• Press Ctrl + P or select "Print" from the file menu. • Under "Printer," select "Microsoft Print to PDF". • Click "Print" - Give your file a name and choose where to save the file.	• Select File > Print (or press Command + P). • Click the PDF button or dropdown menu, usually found in the bottom-left corner of the print dialog box. • Choose Save as PDF from the menu. • Give your file a name and select a location to save it.

You DO NOT need to print this page.

PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
Premium Care. Personal Touch.

PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
Dr. Kavita Namjoshi M.D.
Anabelle Hayes FNP
Ph: 703-662-3359 Fax: 703-956-1307 www.phcnva.com
1800 Town Center Dr, Suite 313
Reston, VA 20190

NEW PATIENT REGISTRATION FORM

Date_____

PATIENT INFORMATION:

Last Name: _____ First Name: _____Middle: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone Number: Cell: _____ Home: _____ Work: _____
Date of Birth: _____ Gender: ☐ M ☐ F Social Security #: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D
Race/Ethnicity:

☐ White (non-Hispanic) ☐ Black (non-Hispanic) ☐ Hispanic
☐ Asian/Asian American/Pacific Islander ☐ American Indian or Alaska Native ☐ Other/Unknown

Preferred Language: _____ Email address: _____

PATIENT EMPLOYER INFORMATION:

Name of Company: _____
Street Address: _____
City_____ State_____ Zip_____

PRIMARY INSURANCE INFORMATION

Name Of Insurance Company_____ Phone _____
ID/Subscriber Number_____ Group Number_____
Subscriber Name_____Relationship To Patient_____
Subscriber SSN _____ Subscriber DOB _____ Subscriber Gender ☐ M ☐ F ☐ O

SECONDARY INSURANCE INFORMATION (if applicable)

Name Of Insurance Company_____ Phone _____
ID/Subscriber Number_____ Group Number _____
Subscriber Name_____Relationship To Patient_____
Subscriber SSN _____ Subscriber DOB _____ Subscriber Gender ☐ M ☐ F ☐ O

EMERGENCY CONTACT INFORMATION

Contact 1:
Name/Relationship_____Phone _____

Alternate Contact:
Name/Relationship_____Phone _____

REFERAL SOURCE (if applicable) Who can we thank for the referral?

☐ Internet _____ ☐ Physician _____
☐ Family/Friend _____ ☐ Other _____

OTHER INFORMATION

- Do you have an Advance Medical Directive? ☐ Yes ☐ No
  - If yes, please provide a copy for our record.
- May we contact you to confirm your appointment? ☐ Yes ☐ No
  - If yes, please indicate preferred means of contact(s)
  - Text_____ Telephone_____ Email_____
- Is it okay to leave a Message on your voice mail reminding you of your appointment? ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Premier Health Consultants of Northern Virginia Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Premier Health Consultants of Northern Virginia Inc. and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____
Signature of Patient or Patient Representative Date

_____
Name (Please Type)

NEW PATIENT MEDICAL HISTORY FORM

PREMIER HEALTH CONSULTANTS
OF NORTHERN VIRGINIA
Premium Care. Personal Touch.

PERSONAL MEDICAL HISTORY

✔ **CHECK ALL THAT APPLY**

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Anemia/Bleeding Disorder	☐	☐	
Asthma/COPD	☐	☐	*Specify:*
Arthritis	☐	☐	*Specify:*
Cancer	☐	☐	*type:*
Depression/Anxiety/Bipolar/Suicidal	☐	☐	*Specify:*
Diabetes	☐	☐	*type:*
Irregular Heartbeat / A FIB	☐	☐	
Heart Attack/Angina/Cardiac Stent	☐	☐	
High Blood Pressure *(hypertension)*	☐	☐	
High Cholesterol	☐	☐	
Thyroid Disease/Adrenal Disease	☐	☐	*Specify:*
Renal (kidney) Disease	☐	☐	
Peptic Ulcer/GERD/Colitis	☐	☐	*Specify:*
Stroke/TIA (ministroke)	☐	☐	
Headache/Migraine	☐	☐	*Specify:*
Epilepsy	☐	☐	
Glaucoma	☐	☐	
Gout	☐	☐	
HIV	☐	☐	
Pneumonia/Tuberculosis	☐	☐	*Specify:*
Others: *Use last page to list additional diagnoses*	☐	☐	

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(mg., pill, etc.)*	TIMES PER DAY	AM	PM
VITAMINS/ SUPPLEMENTS:	☐ YES ☐ NO			

******PLEASE USE LAST PAGE TO LIST ADDITIONAL MEDICATIONS***

PHARMACY OF CHOICE

Pharmacy: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Ph. No: _____

SURGERIES

TYPE *(specify location)*	**DATE**	**LOCATION/FACILITY**

******PLEASE USE LAST PAGE TO LIST ADDITIONAL SURGERIES***

FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ **CHECK ALL THAT APPLY**

Family Member	Alive	Deceased	Alcohol/Drug Abuse (specify)	Asthma	Cancer (Type_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal (specify)	Diabetes Type:	Early/Sudden Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migranes	Other_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other																		

Family Member: Illness/Cancer Type:

_____ _____

_____ _____

_____ _____

_____ _____

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
PRIMARY CARE PHYSICIAN *(specify if current/past)*		
CARDIOLOGIST		
GASTROENTEROLOGIST (GI)		
NEUROLOGIST		
OB/GYN		
OPTHALMOLOGIST		
PULMONOLOGIST		
SURGEON *(specify)*		
UROLOGIST		
NEPHROLOGIST		
OTHERS: *(specify)*		
OTHERS: *(specify)*		
OTHERS: *(specify)*		

SOCIAL HISTORY

Tobacco/Cigarettes	☐ Current user ☐ Former user ☐ Never used	Last date used: _____	Daily usage: _____ ☐ Sticks ☐ Packs	Number of years used: _____
☐ Beer ☐ Wine ☐ Hard Liquor ☐ Other	☐ No alcohol	Last date used: _____	#of drinks per week: _____	Packaging: ☐ Glass ☐ Bottle ☐ Can
Do you use Marijuana, CBD or THC for pain management? ☐ **Yes** ☐ **No**		If yes, what type:	Last used:	

REVIEW OF SYSTEMS CHECK ALL THAT APPLY

	CONSTITUTION
☐	Activity change
☐	Appetite change
☐	Chills
☐	Diaphoresis
☐	Fatigue
☐	Fever
☐	Unexpected weight change

	HEAD, EAR, NOSE &THROAT
☐	Congestion
☐	Dental problem
☐	Drooling
☐	Ear discharge
☐	Ear pain
☐	Facial swelling
☐	Hearing loss
☐	Mouth sores
☐	Nosebleeds
☐	Postnasal drip
☐	Rhinorrhea
☐	Sinus pressure
☐	Sneezing
☐	Sore throat
☐	Tinnitus
☐	Trouble swallowing
☐	Voice change

	EYES
☐	Eye discharge
☐	Eye itching
☐	Eye pain
☐	Eye redness
☐	Photophobia
☐	Visual disturbance

	RESPIRATORY
☐	Apnea
☐	Chest tightness
☐	Choking
☐	Cough
☐	Shortness of breath
☐	Strider
☐	Wheezing

	CARDIOVASCULAR
☐	Chest pain
☐	Leg swelling
☐	Palpitations
☐	Syncope (loss of Conciousness)
☐	Light Headedness

	GASTROINTESTINAL
☐	Abdominal distention
☐	Abdominal pain
☐	Anal bleeding
☐	Blood in stool
☐	Constipation
☐	Diarrhea
☐	Nausea
☐	Rectal pain
☐	Vomiting

	ENDOCRINE
☐	Cold intolerance
☐	Heat intolerance
☐	Excessive Drinking (Polydipsia)
☐	Excessive Eating (Polyphagia)
☐	Excessive Urination (Polyuria)

	GENITOURINARY
☐	Difficulty urinating
☐	Dysuria
☐	Enuresis
☐	Flank pain
☐	Frequency
☐	Genital sore
☐	Hematuria
☐	Penile discharge
☐	Penile pain
☐	Penile swelling
☐	Scrotal swelling
☐	Testicular pain
☐	Urgency
☐	Urine decreased

	HEMATOLOGIC
☐	Enlarged Lymph Nodes
☐	Bruises / bleeds easily

	SKIN
☐	Jaundice
☐	Rash
☐	Wound

	ALLERGY/IMMUNO
☐	Environmental allergies
☐	Food allergies
☐	lmmunocompromised

	NEUROLOGICAL
☐	Dizziness
☐	Facial asymmetry
☐	Headaches
☐	Light-headedness
☐	Numbness
☐	Seizures
☐	Speech difficulty
☐	Syncope
☐	Tremors
☐	Weakness

	PSYCHIATRIC
☐	Agitation
☐	Behavior problem
☐	Confusion
☐	Decreased concentration
☐	Dysphoric mood
☐	Hallucinations
☐	Hyperactive
☐	Nervous/Anxious
☐	Self-injury
☐	Sleep disturbance
☐	Suicidal ideas

	MUSCULAR
☐	Arthralgias
☐	Back pain
☐	Gait problems
☐	Joint swelling
☐	Myalgias
☐	Neck pain
☐	Neck stiffness

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pneumovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	COVID-19 Vaccine *(Brand)* : 1st Dose (date) 2nd Dose (date)

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N
PROSTATE EXAM	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N
BONE DENSITY SCAN	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N
EYE EXAM	Date:	Facility/Provider:	Abnormal Result? ☐Y ☐N

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of first menstruation: Age of Menopause:
Frequency (days, i.e., 3-5 days) :	Menses' monthly? ☐Y ☐N
Total number of pregnancies:	Number of Live Births:
Multiple births (twins, triplets, etc.) ☐ Y ☐ N	Pregnancy complications:

Education-Occupation

Occupation/Job Title *(or prior occupation)*	☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled
Employer:	If employed, do you work the night shift? ☐ Y ☐ N
Have you served in the military? ☐ Y ☐ N	If yes, how long and what branch?
Were you deployed? ☐ Y ☐ N	If yes, where?
Service status:	

Habits-Lifestyle

What is your type of diet?	Is there a reason for your particular diet? ☐ Y ☐ N If yes, specify:
Do you exercise regularly? ☐ Y ☐ N What kind of exercise?	Duration: (min) How often:
How many hours do you sleep at night?	Do you have problems sleeping? ☐ Y ☐ N
When was your last eye exam?	Do you wear corrective lenses? ☐ Y ☐ N
When was your last hearing test?	Do you use an assistive listening device? ☐ Y ☐ N
Have you recently traveled outside of the country in the last 30 days? ☐ Y ☐ N If Yes, Please list countries visited.	Have you had any life changes in the last year? ☐ Y ☐ N If yes, please specify:

Household - Sexual Activity

Marital Status:	Do you have children? ☐ Y ☐ N How many?
Lives with:	
Sexually involved currently? ☐ Y ☐ N	Sexual Partner(s) is/are/have been: ☐ Male ☐ Female
Pregnancy Prevention: ☐ None ☐ Condom ☐ Pill/Ring/Patch/Inj/IUD ☐ Vasectomy	
Have you ever been diagnosed with a sexually transmitted disease? ☐ Y ☐ N	If yes, what infection?

ADDITIONAL MEDICAL HISTORY ONLY. **DO NOT DUPLICATE from previous pages**

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

ADDITIONAL MEDICATIONS

MEDICATIONS	DOSE	TIMES PER DAY		
			AM ☐	PM ☐
			☐	☐
			☐	☐
			☐	☐

ADDITIONAL SURGICAL HISTORY

TYPE (specify left/right)	DATE	LOCATION/FACILITY

ADDITIONAL IMMUNIZATIONS

ADDITIONAL ALLERGIES

ALLERGY	ALLERGIC REACTION

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It is important to provide a complete and accurate medical history, including all medications.

Providing detailed and complete information ensures that we can deliver the safest and most effective care for you.

Incomplete or inaccurate information provided may affect your care and impact your health.

I attest that the entire history (including medications), that I have provided is accurate and complete.

_____	_____	_____
Name	Signature	Date