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

PREMIER HEALTH CONSULTANTS OF NORTHERN VIRGINIA
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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 _____
Subsriber SSN_____-_____-_____ Subscriber DOB __/__/_____ (MM / DD / YYYY) **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 _____
Subsriber 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; If No, please ask for information.
- May we contact you to confirm your appointment? ☐ Yes ☐ No
- If yes, please indicate preferred Means of Contact and circle 1-2-3 in order of priority
- Telephone_____Email Address_____Text_____
- 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
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ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(mg., pill, etc.)*	TIMES PER DAY

****Please use last page to list additional medications*

PHARMACY OF CHOICE

Pharmacy: _____

Address:_____**City**: _____

State:_____**Zip Code**: _____

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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/Tubercolosis *(specify)*			
Others: _____ *Please use last page to list additional diagnoses*			

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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	Early/Sudden Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:																		

Family Member: **ILLNESS / CANCER TYPE:**

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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)_____ 3rd 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? (yes/no) _____
Total number of pregnancies: _____	Number of Live Births: _____
Multiple births (twins, triplets, etc.) _____	Pregnancy complications: _____

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OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
CARDIOLOGIST		
ENT		
GASTROENTEROLOGST (GI)		
NEUROLOGIST		
OB/GYN		
OPTHALMOLOGIST		
PULMONOLOGIST		
SURGEON *(specify)*		
UROLOGIST		
PRIMARY CARE PHYSICIAN *(specify if current/past)*		
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 ☐ No alcohol usage	☐ Social ☐ Occasional ☐ Light ☐ Heavy	Last date used: _____	#of drinks per week: _____	Packaging: ☐ Glass ☐ Bottle ☐ Can
Have you ever used any illegal or street drugs?_____ If yes, what type:_____ Last used: _____				

Education-Occupation

Occupation/Job Title *(or prior occupation):* _____	☐Retired ☐Unemployed ☐LOA ☐Disabled
Employer: _____	If employed, do yo work in the night shift? _____
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 you particular diet? 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		Have you had any life changes in the last year? 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 infection? ☐Y ☐N		If yes, what infection? _____

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REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
☐ Activity change	☐ Chest pain	☐ Color change
☐ Appetite change	☐ Leg swelling	☐ Pallor
☐ Chills	☐ Palpitations	☐ Rash
☐ Diaphoresis	**Gastrointestinal**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**ALLERGY/IMMUNO**
☐ Fever	☐ Abdominal pain	☐ Environmental allergies
☐ Unexpected weight change	☐ Anal bleeding	☐ Food allergies
HEAD, EAR, NOSE &THROAT	☐ Blood in stool	☐ Immunocompromised
☐ Congestion	☐ Constipation	**NEUROLOGICAL**
☐ Dental problem	☐ Diarrhea	☐ Dizziness
☐ Drooling	☐ Nausea	☐ Facial asymmetry
☐ Ear discharge	☐ Rectal pain	☐ Headaches
☐ Ear pain	☐ Vomiting	☐ Light-headedness
☐ Facial swelling	**ENDOCRINE**	☐ Numbness
☐ Hearing loss	☐ Cold intolerance	☐ Seizures
☐ Mouth sores	☐ Heat intolerance	☐ Speech difficulty
☐ Nosebleeds	☐ Polydipsia	☐ Syncope
☐ Postnasal drip	☐ Polyphagia	☐ Tremors
☐ Rhinorrhea	☐ Polyuria	☐ Weakness
☐ Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
☐ Sneezing	☐ Difficulty urinating	☐ Adenopathy
☐ Sore throat	☐ Dysu ria	☐ Bruises / bl eeds easily
☐ Tinnitus	☐ Enuresis	**PSYCHIATRIC**
☐ Trouble swallowing	☐ Flank pain	☐ Agitation
☐ Voice change	☐ Frequency	☐ Behav ior problem
EYES	☐ Genital sore	☐ Confusion
☐ Eye discharge	☐ Hematuria	☐ Decreased concentration
☐ Eye itching	☐ Penile discharge	☐ Dysphoric mood
☐ Eye pain	☐ Penile pain	☐ Hallucinations
☐ Eye redness	☐ Penile swelling	☐ Hyperactive
☐ Photophobia	☐ Scrotal swelling	☐ Nervou s/ anxi ous
☐ Visual disturbance	☐ Testicular pain	☐ Self-injury
RESPIRATORY	☐ Urgency	☐ Sleep disturbance
☐ Apnea	☐ Urine decreased	☐ Suicidal ideas
☐ Chest tightness	**MUSCULAR**	
☐ Choking	☐ Arthralgias	
☐ Cough	☐ Back pain	
☐ Shortness of breath	☐ Gait problems	
☐ Strider	☐ Jo int swelling	
☐ Wheezing	☐ Myalgias	
	☐ Neck pain	
	☐ Neck stiffness	

Patient Name:_____ DOB: _____

ADDITIONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS

ADDITIONAL MEDICATIONS

MEDICATIONS	DOSE	TIMES PER DAY

ADDITIONAL SURGICAL HISTORY

TYPE (specify left/right)	DATE	LOCATION/FACILITY

ADDITIONAL IMMUNIZATIONS

ADDITIONAL ALLERGIES

ALLERGY	ALLERGIC REACTION