

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:

<u>Steps to Print to PDF in Windows:</u>	<u>Steps to Print to PDF on Mac:</u>
<ul style="list-style-type: none">• 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.	<ul style="list-style-type: none">• 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

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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 _____

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 _____

REFERRAL 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 and circle 1-2-3 in order of priority
 - Telephone _____ Email _____ 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 <i>(Please list ALL)</i>	DOSE <i>(mg., pill, etc.)</i>	TIMES PER DAY	
		AM	PM
ASPRIN : YES NO	DOSE		
NSAIDS: YES NO	Ibuprofen, Motrin, Advil, Naprosyn	meloxicam, diclofenac sodium, Celebrex	
VITAMINS/ SUPPLEMENTS:	YES NO		

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

PERSONAL MEDICAL HISTORY

✓ CHECK ALL THAT APPLY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Anemia/Bleeding Disorder			
Asthma/COPD (<i>specify</i>)			
Arthritis (<i>specify</i>)			
Cancer (<i>type: _____</i>)			Type/Date:
Depression/Anxiety/Bipolar/Suicidal (<i>specify</i>)			
Diabetes (<i>type: _____</i>)			
Irregular Heartbeat / A FIB			
Heart Attack/Angina/Cardiac Stent			
High Blood Pressure (<i>hypertension</i>)			
High Cholesterol			
Thyroid Disease/Adrenal Disease (<i>specify</i>)			
Renal (kidney) Disease			
Peptic Ulcer/GERD/Colitis (<i>specify</i>)			
Stroke / TIA (ministroke)/Epilepsy			
Headache / Migraine (<i>specify</i>)			
BPH (Prostate Enlargement)			
Glaucoma / Cataract/ Uveitis			
Gout / Rheumatoid / Lupus			
Obstructive Sleep Apnea			CPAP/BIPAP YES NO
Other:			
Others: <i>Please use last page to list additional diagnoses</i>			

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	Migranes	Other _____	
Mother																			
Father																			
Brother																			
Sister																			
Child																			
MGM																			
MGF																			
PGM																			
PGF																			
Other																			

Family Member:

Cancer Type:

OTHER PROVIDERS/SPECIALISTS

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

SOCIAL HISTORY

Tobacco/Cigarettes	<input type="checkbox"/> Current user <input type="checkbox"/> Former user <input type="checkbox"/> Never used	Last date used: _____	Daily usage: _____ <input type="checkbox"/> Sticks <input type="checkbox"/> Packs	Number of years used: _____
<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard Liquor <input type="checkbox"/> Other	No alcohol	Last date used: _____	#of drinks per week: _____	Packaging: <input type="checkbox"/> Glass <input type="checkbox"/> Bottle <input type="checkbox"/> 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 Consciousness)
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
Immunocompromised

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

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