PRIVIA
MEDICAL GROUP

Patient Information

Last Name ______________________

First Name ______________________

Middle Name ______________________

Former Last Name ______________________

Sex ______________________

DOB ______________________

SSN ______________________

Address ______________________

Address 2 ______________________

Zip ______________________

City ______________________

State ______________________

Home phone ______________________

Mobile phone ______________________

Work phone ______________________

Email (required) ______________________

Preferred Pharmacy ______________________

Contact preference (please circle): HOME MOBILE WORK

Language ______________________

Race ______________________

Ethnicity ______________________

Marital Status ______________________

Homebound? YES NO

How did you hear about us? **(please circle options below)**

Advertising Primary Care Physician Specialist Physician Word of Mouth

Insurance Patient in Practice Hospital Insurance Co. Other

Specify (if Other, above) ______________________

Today's Date ______________________

Guardian

Last Name ______________________

First Name ______________________

Middle name ______________________

Emergency Contact

Name ______________________

Relationship ______________________

Home phone ______________________

Mobile phone ______________________

Next of Kin

Name ______________________

Relationship ______________________

Phone ______________________

Employment

Employer name ______________________

Employer phone ______________________

Guarantor Information

Last Name ______________________

First Name ______________________

Middle name ______________________

DOB ______________________

Address ______________________

Address 2 ______________________

Zip ______________________

City ______________________

State ______________________

Optional Information

SSN ______________________

Phone ______________________

Primary Insurance Information

Insurance Plan Name ____________________

ID/Certification No. ____________________

Policy/Group No. ____________________

Secondary Insurance Information

Insurance Plan Name ____________________

ID/Certification No. ____________________

Policy/Group No. ____________________

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: ____________________

Last Name ____________________

First Name ____________________

Middle Name ____________________

Address ____________________

Address (ctd) ____________________

City ____________________

State ____________________

Zip ____________________

Date of Birth ____________________

Policy Holder Sex ____________________

Employer Name ____________________

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: ____________________

Last Name ____________________

First Name ____________________

Middle Name ____________________

Address ____________________

Address (ctd) ____________________

City ____________________

State ____________________

Zip ____________________

Date of Birth ____________________

Policy Holder Sex ____________________

Employer Name ____________________

PRIVIA
MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information
I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Privia, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in the Privia network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification
In consideration of services provided to me by Privia and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment
As a Privia patient, I voluntarily consent to the rendering of such care and treatment as the Privia providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Privia provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call
I understand and agree that Privia may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Privia.

I understand that I may voluntarily "opt-in" to receive automated text message communications from Privia and its partners by informing my provider's staff or visiting "My Profile" on my Privia Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received Privia's Financial Policy and Notice of Privacy Practices. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Privia providers.

Printed Name of Patient: Date:

Signature: ____________________
To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

***Note: If patient declines to participate in HIE, patient must follow the appropriate procedure outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.**

PRIVIA
MEDICAL GROUP

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: **Date of Birth:**

I prefer to be contacted in the following manner (check all that apply):

☐ **Home Telephone:**______________________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cell Phone:**______________________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**______________________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication:**______________________________
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address

☐ **Other:**__________________________________

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share you information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. **Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.**

Please indicate the person(s) you prefer we share your information with below:

- **Name:**__________________**Telephone:**__________**Relationship:**____________
- **Name:**__________________**Telephone:**__________**Relationship:**____________
- **Name:**__________________**Telephone:**__________**Relationship:**____________

Patient Signature: __________________________________ **Date: 01/05/2017**
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: ______________________________

Other concerns: ______________________________

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.______________	______________
2.______________	______________
3.______________	______________

FAVORITE PHARMACY

____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.______________	______________	______________
2.______________	______________	______________
3.______________	______________	______________
4.______________	______________	______________
5.______________	______________	______________
6.______________	______________	______________
7.______________	______________	______________
8.______________	______________	______________

IMMUNIZATION HISTORY

Immunizations and most recent date:

- Chickenpox Date:____________
- Flu Shot Date:____________
- Gardasil/HPV Date:____________
- Hepatitis A Date:____________
- Hepatitis B Date:____________
- Meningococcus Date:____________
- MMR *(Measles, Mumps, Rubella)* Date:____________
- Pneumonia Date:____________
- Tdap *(Tetanus and pertussis)* Date:____________
- Tetanus Date:____________
- Zostavax *(Shingles)* Date:____________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date ____________ • Abnormal

Last Mammogram Date ____________ • Abnormal

Age of first menstrual period: ________

Date of last menstrual period or age of menopause: ____________

Number of pregnancies: ______ births: ______

miscarriages: ______ abortions: ____________

• Cesarean sections If yes, then number: ______

- Bleeding between periods
- Heavy periods
- Extreme menstrual pain
- Vaginal itching, burning, or discharge
- Wake in the night to go to the bathroom
- Hot flashes
- Breast lump or nipple discharge
- Painful intercourse
- Sexually active
  - Current sexual partner is • Female • Male
  - Do you use condoms • Yes • No
  - Other Birth control method used:____________
  - Interested in being screened for STDs

PAST MEDICAL HISTORY

Please check all that apply:

- Anxiety Disorder
- Arthritis
- Asthma
- Bleeding Disorder
- Blood Clots (or DVT)
- Cancer
- Coronary Artery Disease
- Claustrophobic
- Diabetes - Insulin
- Diabetes - Non-Insulin
- Dialysis
- Diverticulitis
- Fibromyalgia
- Gout
- Has Pacemaker
- Heart Attack
- Heart Murmur
- Hiatal Hernia or Reflux Disease
- HIV or AIDS
- High Cholesterol
- High Blood Pressure
- Overactive Thyroid
- Kidney Disease
- Kidney Stones
- Leg/Foot Ulcers
- Liver Disease
- Osteoporosis
- Polio
- Pulmonary Embolism
- Reflux or Ulcers
- Stroke
- Tuberculosis
- Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. ____	____	____	____
1. ____	____	____	____
3. ____	____	____	____
4. ____	____	____	____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Grandfather (maternal)	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Grandmother (paternal)	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Grandfather (paternal)	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Father	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Mother	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Brother/Sister	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Brother/Sister	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke
Other:______	Y/N	____	Alcoholism, Arthritis, Depression, Cancer, Diabetes, Genetic disease, Heart disease, Hypertension, Osteoporosis, Stroke

SOCIAL HISTORY

Education
- Less than 8th grade
- High school
- 2 year college
- 4 year college
- Post graduate

Marital Status
- Married
- Single
- Divorced
- Separated
- Widowed
- Domestic partner

Caffeine
- None
- Occasional
- Moderate
- Heavy

\# of cups/cans per day? ____

Alcohol
Do you drink alcohol?
- Yes
- No

If so, how often?

If not currently, did you ever use tobacco?
- Yes
- No
- Cigarettes -____pks./day
- Chew - ____/day
- Cigars - _____/day
- \# of years____

Or year quit __________

Drugs
Do you currently use recreational or street drugs?
- Yes
- No

Exercise Level

- None (No exercise)
- Occasional exercise
- Moderate exercise
- High level exercise

- Occasionally
- < 3 times a week
- > 3 times a week

How many drinks per week? __

If yes, list:

____

____

Tobacco

Do you use tobacco?

- Yes
- No

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular
- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional
- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (____lbs)
- Weight Loss (____lbs)

Eyes
- Dry Eyes
- Irritation
- Vision Change

Date of Last Exam:__________

Ears/Nose/Mouth/Throat
- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine
- Fatigue
- Increased Thirst/Hunger/Urination

Gastrointestinal
- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary
- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic
- Easy Bruising/Bleeding
- Swollen Glandsv

Integumentary (Skin)
- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal
- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological
- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric
- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory
- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

Please add any other information about your health that you would like your provider to know here:

____

____

____

____

______________________________ Parent, Guardian, or Caregiver Signature

______________________________ Date