LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

THE UROLOGY GROUP

Date_____

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please circle one)* Single Married Divorced Widowed Partner	STUDENT *(please circle one)* No Full Time Part Time
MAILING ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELL PHONE
RACE *(please circle one)* White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native	ETHNICITY *(please circle one)* Hispanic or Latino Not Hispanic or Latino Unknown	PREFERRED LANGUAGE English Spanish Or other: _____

EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
PREFERRED PHARMACY	PHARMACY PHONE NUMBER	***PATIENT EMAIL ADDRESS***	

WHO REFERREDF YOU TO THIS PRACTICE _____

PRIMARY CARE PHYSICIAN (1ST/LAST NAME) _____ PHONE _____

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle at least one)* Emergency Contact Next of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
MAILING ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER	WORK PHONE	JOB TITLE	

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please circle at least one)* **Guarantor** Emergency Contact Next of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
MAILING ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER	WORK PHONE	JOB TITLE	

Over

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSCIAN (pcp) &/or REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

_____ _____

Print Name **Date**

_____

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date**

_____

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

LOUDOUN MEDICAL GROUP/THE UROLOGY GROUP
AUTHORIZATON TO DISCLOSE HEALTH INFORMATION

ADDITIONAL CONTACT INFORMATION

Please be advised. We cannot give information to anyone without your written consent. I authorize The Urology Group to speak with the person(s) listed below regarding my medical care.

NAME	PHONE	RELATIONSHIP

I authorize The Urology Group to leave a voice mail message at the following number(s). Messages may at times include some protected health information, including appointment reminders, test results and instructions. I understand that with my signature I am authorizing the release of oral communication by The Urology Group to this voice mail number(s).

HOME	CELL	WORK
SIGNATURE	DATE	

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient Name

I have received a copy of Loudoun Medical Group's Notice of Primary Practices and understand that the notice describes how my/the patient's medical information may be used and now access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

Signature: _____

Date: _____

Relationship to Patient _____
(If Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledge, but was unable to do so as documented below:

Date: _____ Staff Initials: _____ Reason: Refused to sign Other:

THE UROLOGY GROUP

New Patient Health History *(page 1 of 3)*

Name:_____ Today's Date:_____
Date of Birth: _____ Age:_____
Primary Care Doctor:_____ Primary Care Phone #:_____
Referring Doctor:_____ Referring Doctor Phone #:_____

Preferred Pharmacy (if known) (name, city, phone #)_____

CHIEF COMPLAINT
What is the main reason you are seeing the doctor today? _____
_____

Please fill in below, or attach list if available.

ALLERGIES (please list all medication allergies and those to shellfish, etc.):

_____

If no allergies, check here ☐

MEDICATIONS (please list all meds including over-the-counter meds, supplements and vitamins): _____
_____
_____

If no medications, check here ☐

MEDICAL PROBLEMS:

__Heart Disease	__Hepatitis	__Glaucoma
__Diabetes	__Renal Disease	__Mitral Valve Prolapse
__High Cholesterol	__Thyroid Disorders	__Migraine Headaches
__High Blood Pressure	__Chronic Urinary Tract Infections	__Infectious Mono
__Low Blood Pressure	__Arthritis	__HIV
__Stroke	__Anemia	__Eczema
__COPD/Emphysema	__Epilepsy	__Hemorrhoids
__Asthma	__Blood Transfusion	__Tuberculosis
__Bronchitis	__Plasma Transfusion	__Other:_____

If no medical problems, check here ☐

SURGERIES:

__Tonsillectomy	__C-Section	__Knee Surgery
__Wisdom Tooth	__D&C	__Laparoscopy
__Appendectomy	__Hysterectomy	__Hernia Repair
__Gallbladder Surgery	__Vasectomy	__Colonoscopy
__Tubal Ligation	__Shoulder Surgery	__Other:_____

If no prior surgeries, check here □

WEIGHT: _____ HEIGHT: _____

When was your last EKG?_____Where? _____
When was your last chest x-ray?_____Where? _____

NAME:_____ **DOB:**_____

SOCIAL HISTORY (*Please check)*
Occupation: _____
Marital status: Single Married Separated Divorced Widowed

Tobacco Use:
☐ Never Smoked
☐ Former Smoker
☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Smoker Current Status Unknown
☐ Current Smokeless Tobacco User
☐ Unknown if ever smoked
☐ Exposure Secondhand Smoke

Do you drink alcohol? ☐ No ☐ Yes ☐ Prior History of abuse
What is your caffeine use: ☐ No ☐ 1-2 cups/day ☐ More than 3 cups/day
Do you use street drugs? ☐ No ☐ Yes

FAMILY HISTORY

	Father	Mother	Brother	Sister	PGF*	PGM*	MGF*	MGM*
Prostate Cancer								
Renal Cancer								
Bladder Cancer								
Testicular Cancer								
Heart Attack								
Heart Disease								
Stroke								
High Blood Pressure								
High Cholesterol								
Diabetes								
Kidney Disease								
Urinary Stones								
Cystic Fibrosis								
Tuberculosis								
Other Cancer type: _____								
Other Family Hx:_____								

If there is no family history of any of the above, check here ☐

If family history is not available (unknown or unobtainable), please check here ☐

* PGF – Paternal grandfather (father's father)
PGM – Paternal grandmother (father's mother)
MGF – Maternal grandfather (mother's father)
MGM – Maternal grandmother (mother's mother)

MEDICAL HISTORY

Do you now, or have you had any problems related to the following symptoms:
If not checked, it will mean that you **do not** have that symptom or condition.

General
__Fatigue
__Night Sweats
__Chills
__Weight Gain
__Weight Loss

Skin
__Ulcers
__Rash
__Itching
__Lesions

Head
__Chronic Headaches
__Head Injury/Trauma

Eyes
__Vision Loss
__Double Vision
__Visual Disturbances

Ear, Mouth, Nose And Throat
__Ear Ringing
__Nosebleeds
__Hoarseness
__Decreased Hearing
__Bleeding from Gums

Respiratory
__Chronic Cough
__Wheezing
__Difficulty Breathing

Heart
__Chest Pain
__Murmur (req antibiotics)
__Palpitations

Gastrointestinal
__Constipation
__Diarrhea
__Nausea
__Vomiting
__Rectal Bleeding

Urinary
__Blood in Urine
__Incontinence
__Kidney Stones
__Frequency
__Urgency
__Venereal Disease/STDs

Muscular-Skeletal
__Back Pain
__Joint Pain
__Joint Swelling
__Muscle Weakness
__Muscular Pain or Tenderness

Neurological
__Dizziness
__Seizures
__Tremor

Psychiatric
__Anxiety
__Depression
__Mood Changes

Endocrine
__Appetite Changes
__Sexual Dysfunction

Hematology
__Easy Bruising
__Prolonged Bleeding

If none of the above symptoms, check here □

NAME:_____ **DOB:**_____