SURGICAL SPECIALISTS OF NORTHERN VIRGINIA

Surgery Evaluation Form: Please fill out completely & print clearly.

			Date:
First:	**Middle:**	**Last:**	
Birthdate:	**Age:**	**Height:**	**Weight:**

Who referred you to our practice? _____

Who is your primary care physician? _____

Reason for Visit: _____ **Duration:** _____

Preferred Pharmacy: (Name, City and Phone Number) _____

List other physicians you are seeing:

Physician Name	**Specialty**

Allergies (Medications, food, environmental, latex, adhesive)	**Reaction**

Medications: (List all current medications)

Date started	**Medication & Dose**	**Directions**	**Reason for Taking**	**Prescribed by**

_____ J. Lesniewski **_____ D. Meikle** **_____ M. Peters**

Past Medical History: (Please check any past medical history and/or list any past medical history under other)

☐ **Attention Deficit Disorder**	☐ **GI Dizziness/Vertigo**	☐ **High cholesterol**	☐ **Pneumonia**
☐ **Alcohol Disorder/Drug addiction**	☐ **Easy Bleeding**	☐ **Hiatal Hernia**	☐ **Psoriasis**
☐ **Anemia**	☐ **EKG (list year)** _____	☐ **HIV Infection**	☐ **Reflux**
☐ **Arrhythmia**	☐ **Emphysema**	☐ **Hodgkin's Disease**	☐ **Rheumatoid Arthritis**
☐ **Arthritis**	☐ **Epilepsy**	☐ **Insomnia**	☐ **Seizure Disorder**
☐ **Asthma**	☐ **Esophageal Reflux**	☐ **Kidney Dialysis**	☐ **Sickle Cell Disease**
☐ **Artificial joints**	☐ **Fatigue**	☐ **Kidney poor function**	☐ **Skin Disease**
☐ **Back Problems**	☐ **Fibromyalgia**	☐ **Kidney stones**	☐ **Sleep Apnea**
☐ **Blood clots in legs**	☐ **Gallstones**	☐ **Leukemia**	☐ **STDs**
☐ **Bronchitis**	☐ **Gastrointestinal Disorder**	☐ **Lung disease**	☐ **Stomach Ulcers**
☐ **Cancer (list type)** _____	☐ **Glaucoma**	☐ **Lupus**	☐ **Stroke Syndrome**
☐ **Colon polyps**	☐ **Gout**	☐ **Lyme Disease**	☐ **Thyroid Disorders**
☐ **Concussion**	☐ **Headache**	☐ **Melanoma**	☐ **Tuberculosis**
☐ **Congestive Heart Failure**	☐ **Heart Attack**	☐ **Migraine or** ☐ **Headache**	☐ **Ulcer disease**
☐ **COPD**	☐ **Hemorrhoids**	☐ **Osteoporosis**	☐ **Urinary tract infections**
☐ **Depression**	☐ **Hepatitis or** ☐ **Jaundice**	☐ **Pancreatitis**	☐ **Diabetes Mellitus**
☐ **High Blood Pressure**	☐ **Other (List)** _____		

Please list any surgeries: (Please write year of surgery and type)

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Do you have a pacemaker or implanted device? If so, please list: _____
_____

Tuberculosis Symptom Screening: (Please check Yes or No)

Have you had contact with anyone with active tuberculosis disease in the past year? ☐ Yes ☐ No	
Have you had a TB Skin Test? ☐ Yes ☐ No	**Have you ever been treated for TB? ☐ Yes ☐ No**

Family History: (All medical problems, surgeries, cancer and cause of death)

	Medical Problems	**Surgeries**	**Cancer**	**Cause of death (age)**
Mother:				
Father:				
Sisters:				
Brothers:				
Grandparents:				

Other: (Please list any significant health issues with Aunts, Uncles, Cousins, and Children. Please specify who has the specific issue.)

_____

Social History: (Please write and/or check the appropriate answer)

Who lives with you?	
Occupation	
Do you currently smoke?	**☐ Yes ☐ No ☐ Former**
How much per day do you smoke?	**_____ Pack per day or _____ cigarettes per day**
What do you smoke? (i.e. cigars)	
Do you drink alcohol?	**☐ Yes ☐ No**
How often do you drink?	**☐ Daily ☐ Weekly ☐ Monthly ☐ Social Drinker**
Do you currently use recreational drugs?	**☐ Yes ☐ No**
Have you ever used recreational drugs?	**☐ Yes ☐ No**
Please specify type and extent of use:	
Are you pregnant?	**☐ Yes ☐ No**
Date of Last Menstrual cycle?	

Review of Systems: (Please circle **ALL** symptoms within the past 3 months for each category below).

General/constitutional

☐ Fever ☐ Weight loss ☐ Change in appetite ☐ Headaches ☐ Night sweats ☐ Recent illness
☐ Weight gain ☐ Chills ☐ Fatigue ☐ Sleep disturbance

ENT

☐ Sore throat ☐ Nasal congestion ☐ Sinus ☐ Difficulty swallowing ☐ Eye problems
trouble ☐ Dizziness ☐ Nosebleed ☐ Hearing loss

Cardiovascular

☐ Anemia ☐ Easy bruising ☐ Murmurs ☐ Blood clots ☐ Difficulty lying flat
☐ Edema ☐ Ankle swelling ☐ Swelling ☐ Chest Pain ☐ Heart Palpitations
in Hands/Feet ☐ Shortness of Breath

Respiratory

☐ Breathing problems ☐ Cough ☐ Wheezing ☐ Coughing up Blood ☐ Shortness of Breath

Gastrointestinal

☐ Gas/bloating ☐ Acid reflux ☐ Hemorrhoids ☐ Diarrhea ☐ Indigestion
☐ Lower abdominal pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Vomiting blood
☐ Upper abdominal pain ☐ Stomach problems ☐ Rectal pain ☐ Rectal Bleeding

Genitourinary

☐ Urine leakage ☐ Kidney stones ☐ Large ☐ Heavy uterine bleeding ☐ Frequent
prostate ☐ Erectile dysfunction urination ☐ Painful urination
☐ Difficulty urinating

Musculoskeletal

☐ Back pain ☐ Arthritis ☐ Neck problems ☐ Limb weakness ☐ Leg cramps
☐ Muscle aches ☐ Joint stiffness

Neurologic

☐ Seizures ☐ Tingling ☐ Numbness ☐ Loss of consciousness ☐ Loss of balance

Psychological

☐ Anxiety ☐ Depressed Mood ☐ Treatment for emotional or psychiatric
☐Fear/phobia ☐ Auditory/visual hallucinations disorder

Skin

☐ Hives ☐ Skin Rashes ☐ Skin Lesions

Completed Date: _____

PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other: _____ Patient*: _____ Suffix: Jr./Sr./Other: _____
(Last, First, Middle Initial)

Previous Name: _____ Preferred Name: _____

Mailing Address*: _____
(Street Address, City, State, Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP): _____ Address: _____ Phone #: _____
(First, Last)

Referring Provider: _____ Address: _____ Phone #: _____
(First, Last)

Date of Birth*: _____ Sex*: _____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
(mm/dd/yyyy)

Social Security #: _____ - _____ - _____ Employer Name: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Email: _____

Race*: ☐ Caucasian/White ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Pharmacy Name*: _____ Address: _____ Phone #: _____
(Street Address, City, State, Zip)

Emergency Contact*

Name: _____ Relationship: _____
(Last, First)

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Work #: _____ Cell #: _____

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name: _____ Date of Birth: _____ Sex: _____Social Security #: _____ - _____ - _____
(Last, First, mm/dd/yyyy)

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Primary Insurance Information*

Insurance Name: _____ Member ID #: _____ Relationship to Insured: _____

Employer: _____Group #: _____ Effective Date: _____
(mm/dd/yyyy)

Insured's Information* - (if not self)

Name: _____ Date of Birth: _____ Sex: _____ Social Security #: _____ - _____ - _____
(Last, First, mm/dd/yyyy)

Relationship to Insured: _____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Work #: _____ Cell #: _____

Secondary Insurance Information

Insurance Name: _____ Member ID #: _____ Relationship to Insured: _____ Group #: _____ Effective Date: _____

Secondary Insured's Information - (if not self)

Name: _____ Date of Birth: _____ Sex: _____ Social Security #: _____ - _____ - _____
(Last, First, mm/dd/yyyy)

Relationship to Insured: _____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Work #: _____ Cell #: _____

CONSENT INFORMATION

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. **X _____ (Please initial)**

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:

If any LMG health professional, worker or employee should be directly exposed to your blood or your 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. **X _____ (Please initial)**

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 transit 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. **X _____ (Please initial)**

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents
X_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out
X_____ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X _____ (Please initial)**

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

_____
Relationship (if any)

SURGICAL SPECIALISTS OF NORTHERN VIRGINIA

JAMES A. LESNIEWSKI, M.D., F.A.C.S.
DANIEL L. MEIKLE, M.D.
MICHAEL J. PETERS, M.D.

24430 STONE SPRINGS BLVD
SUITE 215
DULLES, VA 20166

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION VIA FAX AS MAY BE DEEMED NECESSARY BY MY PHYSICIAN, WITH REGARD TO MY MEDICAL CARE.

SIGNATURE OF PATIENT **DATE**

ELECTIVE AUTHORIZATION

*****I AGREE TO ALLOW YOU TO SPEAK TO THE FOLLOWING FAMILY MEMBERS OR ACQUAINTANCES CONCERNING MY MEDICAL CARE. YOU MAY CORRESPOND WITH THEM EITHER IN PERSON, VIA PHONE OR MAIL.**

NAME RELATIONSHIP PHONE #

SIGNATURE

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

I, _____ , acknowledge receiving on
(print patient name)

_____, a copy of Loudoun Medical Group's Notice of Privacy Practices.
(print date)

_____
Patient signature or initials

FOR OFFICE USE ONLY

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

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

LOUDOUN MEDICAL GROUP
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC, has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

As medical professionals, we understand that information about you and your health is sensitive and personal. We are also required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and copy our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from April 10, 2003 until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.

  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment.*** We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in connection with payment for your care.

- ***Health care operations.*** We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- Worker's Compensation: In such cases that your treatment is a result of an injury on the job, we may release your information to the appropriate carrier/employer.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments. Please advise us if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise us in writing at our Contact address given above.

We may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

The Law entitles you to:

- Ask us to further restrict our use and disclosure of information about you. We are not required to grant such a request, but if we do we must make sure the restrictions are implemented.
- Receive confidential communications from us, at an alternative address you provide to us.
- Review our records of your information.
- Obtain a copy of all or any part of our records of your information. We may charge you a copying charge of a $10 base fee, $.50 per page for pages 1- 50, then $.25 for any pages over 50.
- Ask us to amend your records, if you believe that they are incorrect or incomplete. We are not required to make such an amendment. If you request an amendment and we determine we will not make it, you are entitled to have a statement of your disagreement included in your records. If you do include a statement of disagreement in your records, we may include a statement of explanation or response in your records as well.
- Obtain an accounting of all persons to which we have disclosed information about you, for any purpose except your treatment, payment for your treatment, or our health care operations.
- If you believe we have violated your privacy rights, you may forward us a written complaint to our Contact address given above. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. If you do file a complaint we are legally prohibited from retaliating against you.