McLEAN MEDICAL CENTER AND URGENT CARE

6858 Old Dominion Drive, SUITE 102
McLean, VA 22101
(P) 703-847-9800 (F) 703-356-7074

PLEASE VERIFY YOUR CURRENT CONTACT INFORMATION WITH OUR OFFICE BY FILLING THIS SHORT FORM OUT. YOUR COOPERATION IS APPRECIATED.

DATE: _____

NAME: _____ **DOB:** _____

ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE #: _____ **CELL #:** _____

BEST TIME TO CALL: _____ **EMAIL:** _____

SOCIAL SECURITY NUMBER: _____

GENDER: Male Female

RACE: White African American Asian Hispanic Other

PHARMACY Name/Phone: _____

SIGNATURE: _____

McLean Medical Center & Urgent Care

PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. (Please Print)
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date__/__/__ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone	Patient's Social Security#
Person financially responsible for this account	Self Spouse	Responsible Party's Birth Date / /	Responsible Party's Social Security#
Responsible Party Driver License# State: Number:		Occupation	How long at current Employer?
Name of employer Address or ___Not Applicable		Business Phone	Occupation
Reason for Visit:		Referred by: (include address and phone)	
Person to contact in case of emergency:		Relationship to patient	Phone

Medicare Yes [ ] No [ ]	Medicare#	Medicaid Yes [ ] No [ ]	Medicaid#	Effective Date
Medicare Secondary insurance name Address			Policy#	Group#
Worker's Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] If Yes-put W/C or MVA carrier below	Date of Accident	Treatment authorized by	Claim#	W/C or MVA Insurance Phone#
Primary insurance company Address				Is Insurance through your employer?
Subscriber Name	Subscriber birth date	Policy#	Group#	
Secondary insurance name Address			Policy#	Group#

Information Release / Authorization to Treat

Lifetime Assignment of Benefits/

I authorize payment of medical benefits to McLean Medical Center for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my Insurance company or its agent information concerning health care, advise, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatment or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patient Rights and Responsibilities and this facility's Grievance Procedure.

Patient, Parent or Guardian Signature (if child is under 18 years old) _____ Date _____

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MCLEAN, VA 22101

NAME:

REASON FOR TODAY'S VISIT:

MEDICAL HISTORY:

MEDICATION:

1. NON-PRESCRIPTION (CHECK ANY TAKEN REGULARLY)
   - ☐ VITAMINS
   - ☐ LAXATIVES
   - ☐ DECONGESTANT
   - ☐ OTHER: _____
   - ☐ ASPIRIN
   - ☐ ANTACIDS
   - ☐ TYLENOL
2. PRESCRIPTION (INCLUDING BIRTH CONTROL PILLS)

MEDICATION	DOSAGE	TIMES/DAY

IMMUNIZATIONS: (CHECK ANY RECEIVED)

- ☐ MEASLES
- ☐ MUMPS
- ☐ HEMOPHILUS
- ☐ HEPATITIS
- ☐ GERMAN MEASLES
- ☐ SMALL POX
- ☐ PNEUMONIA
- ☐ TB SKIN TESTS: YEAR: _____ POS: ___ NEG: ___
- ☐ TETANUS SERIES (DATES): _____

ALLERGIES: (CHECK ANY THAT YOU ARE ALLERGIC TO)

- ☐ ANIMALS
- ☐ ASPIRIN
- ☐ CODEINE
- ☐ DEMEROL
- ☐ GRASSES
- ☐ INSECT BITES
- ☐ PENICILLIN
- ☐ POLLENS
- ☐ SULFA

OF THE FOLLOWING ARE YOU ALLERGIC TO:

WHICH ANTIBIOTICS? _____

WHICH FOODS? _____

WHICH SEDATIVES? _____

☐ OTHER: _____

☐ NO KNOWN ALLERGIES

HABITS:

DO YOU USE TOBACCO?	☐ YES	☐ NO	☐ CHEW	☐ SMOKE
IF YES, WHAT KIND? _____				
IF YES, HOW MUCH? _____				
DO YOU DRINK ALCOHOL?		☐ YES	☐ NO	
DO YOU USE DRUGS?		☐ YES	☐ NO	
DO YOU DRINK CAFFEINATED BEVERAGES?		☐ YES	☐ NO	
DO YOU WEAR SEAT BELTS?		☐ YES	☐ NO	
DO YOU SLEEP WELL?		☐ YES	☐ NO	
DO YOU EAT WELL?		☐ YES	☐ NO	

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

(WOMEN) DO YOU EXAMINE BREASTS MONTHLY? ☐ YES ☐ NO

HAVE YOU USED NARCOTICS/OTHER ADDICTIVE DRUGS? ☐ YES ☐ NO

TYPES: _____

HAVE YOU BEEN EXPOSED TO CHEMICALS, TOXINS, FUMES, SMOKE, POISONS, OR RADIOACTIVE MATERIALS AT HOME OR WORK?

☐ YES ☐ NO HOW OFTEN? _____

TYPES: _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

☐ MARRIAGE DIFFICULTIES ☐ JOB DIFFICULTIES ☐ EMOTIONAL PROBLEMS ☐ NERVOUS BREAKDOWN

☐ SEXUAL DIFFICULTIES ☐ SEXUAL ATTACK ☐ DEPRESSION ☐ SLEEP DIFFICULTIES

LIST ANY HOSPITAL STAYS INCLUDINBG SURGERIES STARTING WITH MOST RECENT:

DATE	REASON	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER RECEIVED ANY BLOOD TRANSFUSIONS? ☐ YES ☐ NO WHEN? _____

CONDITIONS: (CHECK IF YOU HAVE, OR EVER HAD ANY OF THE FOLLOWING CONDITIONS)

☐ CHEST PAIN OR TIGHTNESS
☐ SERIOUS PROBLEMS WITH EYES OR EARS
☐ PERSISTENT SWOLLEN GLANDS / UNSUAL LUMPS
☐ FREQUENT SWELLING OF ANKLES OR LEGS
☐ UNUSUAL OR SEVERE SHORTNESS OF BREATH
☐ UNUSUAL SKIN PROBLEMS OF PERSISTENT SORES
☐ REDNESS, SEVERE PAIN, OR SWELLING OF JOINTS
☐ FREQUENT/SEVERE BACK PAIN
☐ FREQUENT/SEVERE ABDOMINAL PAIN
☐ FREQUENT/SEVERE CONSTIPATION/DIARRHEA
☐ PAIN/ BURNING WITH URINATION
☐ BREAST LUMP/UNSUAL DISCHARGE
☐ IRREGULAR OR FAST HEARTBEAT
☐ CHANGES IN APPETITE
☐ PREGNANCY PROBLEMS
☐ DIFFICULTY SWALLOWING
☐ LOSS OF CONTROL OF URINATION
☐ GENITAL PROBLEMS
☐ FREQUENT/SEVERE HEADACHES
☐ BLOOD IN STOOL/BLACK STOOL
☐ FREQUENT NAUSEA OR VOMITING
☐ UNEXPECTED WT CHANGE OF >10LBS

FAMILY HISTORY: (CHECK IF THERE IS ANYONE IN YOUR IMMEDIATE FAMILY WITH A HISTORY OF)

☐ ASTHMA	☐ DIABETES	☐ MENTAL RETARDATION	☐ DEPRESSION
☐ BIRTH DEFECTS	☐ HEART ATTACK	☐ NERVOUS BREAKDOWN	☐ CANCER
☐ BLEEDING PROBLEMS	☐ HEART DISEASE	☐ SEIZURES	☐ HIGH BLOOD PRESSURE
☐ CYSTIC FIBROSIS	☐ HIGH CHOLESTEROL	☐ THYROID PROBLEMS	☐ STROKE

WHAT QUESTIONS DO YOU WISH TO ASK THE DOCTOR?

1. _____
2. _____
3. _____

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO

SIGNED: _____ DATE: _____

PATIENT REGISTRATION TERMS AND CONDITIONS

PATIENT AUTHORIZATION FOR INSURANCE PAYMENT

I hereby authorize McLean Medical Center & Urgent Care, to apply for benefits on my behalf for the medical services rendered. I certify that the information I have provided is true and accurate. I understand that my insurance company may request and receive my medical information, if a claim should be filed on my behalf.

REFERRALS

I understand that I am responsible for obtaining a valid "referral form" from my primary care physician, if required by my insurance company. The failure to obtain a required referral may result in the denial of care or non-payment by your insurance company, and payment at time of service may be required.

PRE-CERTIFICATION

I understand that McLean Medical Center & Urgent Care will attempt to obtain a pre-certification as a courtesy to me. I understand that McLean Medical Center & Urgent Care is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure that any required pre-certification has been obtained for me prior to my procedure. I understand that in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

PAYMENT OF MEDICAL BILLS and RETURN CHECK FEES

I agree to promptly pay all charges when billed for medical services rendered. As a parent or legal guardian, I accept legal responsibility for all charges incurred by the child or ward. I understand that McLean Medical Center & Urgent Care will bill me once my financial responsibility is determined. In the event that I do not pay this liability and it becomes necessary for McLean Medical Center & Urgent Care to engage professional collection services, I agree to pay for all legal, attorney and/or collection fees required to pursue the collection and payment for the services provided. The collection fee is 30% of the unpaid balance(s). In the event a check is returned for any reason, a $25 fee shall be imposed. McLean Medical Center & Urgent Care accepts cash, checks, credit card and money order payments.

RIGHT TO PRIVACY, CONFIDENTIALITY (HIPAA) & RELEASE OF MEDICAL INFORMATION

McLean Medical Center & Urgent Care adheres strictly to Federal and State laws regarding confidentiality. We are committed to patient privacy and confidentiality. We will not discuss your medical information without your permission regardless of their relationship to you. If you desire to allow someone else to have access to your medical information, you must so designate in writing your authorization. You will be asked for your permission prior to the release of your medical records,

except for TPO (Treatment, Payment and Health Care Operations). and/or as per other exemptions in law. Your permission is currently not required for TPO under Federal Law. By signing below, I acknowledge that I have been advised that McLean Medical Center & Urgent Care policies are available to me upon request.

MESSAGES/MESSAGING

By indicating either yes or no, or providing an e-mail address, I authorize you to contact me via e-mail or leave a message on my phone with regard to my care, including lab results, appointment and business information.

Preferred Contact Method(s)

E-mail me at _____

Leave a message at Work __Yes __No Home __Yes __No Cell __Yes __No

AGREEMENT TO REGISTRATION TERMS AND CONDITIONS

By signing below, I agree to the terms and conditions, herein, and attest that the information provided is true and accurate.

I understand that I am liable for any charges incurred at the McLean Medical Center & Urgent Care. I will make prompt payment to McLean Medical Center & Urgent Care for any visit not covered by my insurance company.

_____ _____

Signature Date