Last Name: _____

First Name: _____

Birthdate: _____

BAYVIEW PHYSICIANS GROUP

Coastal Surgical Patient Medical History

Allergies (include drugs, foods, chemicals, insects):

Item	Type of Reaction	Item	Type of Reaction

Preferred Pharmacy (include address and phone number if possible):

_____

Medical Illnesses or Conditions:

	Condition	Onset Date	Other Illnesses Not listed Above:
☐	Hypertension	_____	_____
☐	High Cholesterol	_____	_____
☐	Diabetes	_____	_____
☐	Heart Disease	_____	_____
☐	Asthma	_____	
☐	Cancer	_____	

Past Surgical History:

Procedure /Date/ Surgeon	Procedure /Date/ Surgeon

For Females Only:

Onset of First Menstrual Period	Date of Last Mentrual Period	Age of First Pregnancy
Number of Pregnancies: _____	# of Vaginal Deliveries: _____ # of C-Sections: _____	# of Miscarriages/Abortions: _____

Family History

	Living	Dead	Age	Chronic Conditions
Father				
Mother				
Brothers and Sisters				
Children				
Other (Grandparents, Aunts, Uncles, Cousins-specify side of family)				

Last Name: _____
First Name: _____
Birthdate: _____

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Social History:

Tobacco Use: _____ Never Smoker _____ Former Smoker (Amount per day _____ Years: _____) Current Smoker _____ (Amount per day _____ Years: _____)
Consume Alcohol: Type _____ Amount per day _____
Use recreational drugs: Type _____ Amount per day _____

Current Physicians:

Primary Care Physician:
Cardiologist:
Oncologist:
Other Physicians:

Current Medications:

Drug Name	Dose	Drug Name	Dose

Last Name: _____
First Name: _____
Birthdate: _____

Personal History:

Do you have an personal history of or are currently experiencing any of the following? (Please check all that apply)

General
- ❍ Weight loss/gain
- ❍ Fatigue
- ❍ Night Sweats
- ❍ Fevers/Chills

Head:
- ❍ Chronic Headaches
- ❍ Vertigo
- ❍ Injury

Eyes:
- ❍ Blurred Vision
- ❍ Blindness
- ❍ Double Vision
- ❍ Tearing

Ears:
- ❍ Hearing Loss
- ❍ Bleeding
- ❍ Ringing in Ears

Nose:
- ❍ Bleeding
- ❍ Discharge

Neck/Throat:
- ❍ Sinusitis
- ❍ Sore Throat
- ❍ Hoarseness

Breasts:
- ❍ Lumps
- ❍ Pain
- ❍ Swelling
- ❍ Discharge

Chest:
- ❍ Shortness of Breath
- ❍ Wheezing
- ❍ Cough
- ❍ Coughing Blood
- ❍ Emphysema
- ❍ Asthma

Heart:
- ❍ Chest Pain
- ❍ Palpitations
- ❍ Fainting
- ❍ Heart Attack
- ❍ High Blood Pressure
- ❍ Irregular Rhythm
- ❍ High Cholesterol

Abdomen:
- ❍ Change in Appetite
- ❍ Difficulty Swallowing
- ❍ Abdominal Pain
- ❍ Change in Bowel Habits
- ❍ Nausea or Vomiting
- ❍ Blood in Stool
- ❍ Black, Tarry Stool

Genitourinary:
- ❍ Urgency
- ❍ Blood in Urine
- ❍ Urinary Frequency

Musculoskeletal:
- ❍ Muscle or Joint Pain
- ❍ Limitations of Range of Motion
- ❍ Numbness or Tingling

Neurologic:
- ❍ Weakness
- ❍ Tremors
- ❍ Seizures

Psychiatric:
- ❍ Depression
- ❍ Anxiety
- ❍ Change in Sleep Habits
- ❍ Schizophrenia
- ❍ Bipolar
- ❍ Other Psychiatric Conditions _____

Endocrine:
- ❍ Diabetes
- ❍ Heat Intolerance
- ❍ Excessive Thirst
- ❍ Thyroid Disease

Immune:
- ❍ HIV

Are there any other symptoms you have that are not listed?

_____

_____

_____

_____

_____

Last Name: _____

First Name: _____

Birthdate:

BAYVIEW PHYSICIANS GROUP

Bayview Physician Services Office Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy.

To ensure our system is set up accurately, we ask that you complete our registration form and provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients. Any remaining balance will be the patient's responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be the patient's responsibility. Services may require a referral or authorization prior to being seen. Please be aware that some services provided may not be covered by Medicare or other insurances and may be considered not medically necessary, experimental or investigational. Unless valid insurance is presented, patients will be responsible for payment in full at the time of visit. All copayments are to be paid at the time service is rendered.

Please be aware that some visits performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

As a service to our patients, we will send you electronic appointment reminders and possibly other important electronic messages. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not provide your information to any other entity.

To ensure accurate processing of prescriptions, we ask that all refill requests are processed through your pharmacy. Your pharmacy can still request the refill even if you have no refills remaining. Routine refill requests may take up to 48 hours; however our goal is to process all requests the same day.

Referral requests may take several days to process, depending on the insurance company. Please call our receptionist with the name of the specialist, their phone number, date of your appointment and your diagnosis. Also, it may take 24-48 hours to process forms, depending on the amount of detail requested.

We are happy to provide you with a copy of your medical record. There is a fee for copied medical records. We will notify you of the records fee and it should be paid prior to the release of the records. We require at least 5 business days to receive copies of medical records.

We recognize that from time to time, you may need to have a medical form completed. To ensure we are able to meet the appropriate deadlines, please ensure that we receive this form as soon as possible. Depending on the information needed on the form, it could take several days for us to complete it.

Should you arrive late for an appointment, please be aware that you may be asked to reschedule or you may have to wait to be seen between or after the other patients who have arrived at their scheduled time.

Your appointment is very important to us. If you are unable to make your scheduled appointment, unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $50.00. Please help us serve you better by keeping your scheduled appointments.

I, _____ have read, understand and agree to the office policy of Bayview Physicians Group.

Signature of Responsible Party _____ Date _____

Patient Information

BAYVIEW

Patient Information

Last Name	First	Middle Initial	Social Security No.

Address	City	State	Zip Code

Sex	Marital Status	Birthdate	Age	Occupation	Employer
☐ M ☐ F	☐ S ☐ M ☐ D ☐ W	/ /			

Home Phone	Work Phone	Cell Phone

Email Address:	Preferred Contact Method:

Race

- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Other race
- ☐ Asian
- ☐ White/Caucasian
- ☐ Decline

Ethnicity

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline

Preferred Language

- ☐ Decline

Emergency Contact Name	Relationship	Phone

Responsible Party

Responsible Party - Last Name	First	Middle Initial	Birthdate	Social Security No.
			/ /	

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Relationship to Patient	Occupation	Employer

Privacy

HIPAA Acknowledgements: All patients must initial all that apply:

_____ I hereby acknowledge that I have been provided with a copy of the Bayview Physicians Group Notice of Privacy Policies.

_____ Is it ok to leave a message regarding your health information at your : ☐ Home ☐ Cell ☐ No Messages Initials: _____

_____ By default, no other persons may have access to my medical record except the following people:

Name & Relationship	

Insurance

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.

Insurance Co. #1

Company Name		
ID No.	Group No.	
Subscriber's Name	Date of Birth	
Relation to Patient	SS#:	

Insurance Co. #2

Company Name		
ID No.	Group No.	
Subscriber's Name	Date of Birth	
Relation to Patient	SS#:	

Consent, Agreements & Signature

Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - No Guarantee

Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transm human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV o hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed

I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic an therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as an testing and/or treatment carried out by Bayview Physician Services, PC staff under the direction of the Medical Director

I agree that Bayview Physicians Group may request and use my prescription medication history from other healthcare providers or third-part pharmacy benefit payors for treatment purposes

We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or ce phone number, you consent to receive electronic messages by such means. We will not share your information. You can opt out at anytime

Chaperones will be present during certain examinations. Any request for a chaperone made by a patient and/or family member will be honored.

I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment.

Financial Agreement - Insurance Agreement

I hereby authorize treatment to patient by any Bayview Physicians Group provider and/or affiliated medical staff member(s). I further authoriz release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does nc constitute as covered services, including denied Worker's Compensation claims, as well as attorney fees of 33 1/3% and other related costs o collection should such action become necessary.

Signature of Patient/Responsible Party	Relationship to Patient	Date
X		

Last Name: _____

First Name: _____

Birthdate:

BAYVIEW PHYSICIANS GROUP

Acknowledgement of Receipt

I have been given a copy of Bayview Physicians Group's Notice of Privacy Practices, version effective **September 23, 2013**. I consent to the uses and disclosures of my health information as outlined in the Notice.

Privacy Options

☐ **I want NO ONE to receive my Personal Health Information except myself.**

☐ **I request the following person(s) BE ALLOWED to access my Personal Health Information:**

_____ _____

_____ _____

☐ **I request the following person(s) NOT BE ALLOWED to access my Personal Health Information:**

_____ _____

_____ _____

Communications

I give permission to leave a verbal message at my personal residence. ____ **Yes** ____ **No**

I give permission to leave a message regarding my appointment on my voicemail. ____ **Yes** ____ **No**

I give NowCare permission to release any urgent care notes to my personal physician. ____ **Yes** ____ **No**

I give permission to call me at work. Work Phone: _____ ____ **Yes** ____ **No**

Please Sign

Patient's Name (Print)	**Patient's Signature**	**Date**
Lname, Fname		

If you are signing on behalf of the patient, please complete this section:

Representative's Name (Print)	***Representative's Signature***	***Date***

Reason Patient Cannot Sign

***** Office Use Only *****

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it: