Ridgeview Internal Medicine
2000 Opitz Blvd
Woodbridge, VA 22191
Phone 703-494-4116

NEW PATIENT REGISTRATION FORM

Patient Name

Last	First	MI
DOB	SSN	

Home Address

Street	City	State	Zip Code

Phone

Primary	Secondary	Other

Email

Demographic Information

Gender	Race	Language
Marital status	Religion	

Patient employer/School

Name			
Street	City	State	Zip Code

Policy Holder Information

Primary Insurance	ID Number	Group Number
Subscriber's Name	Subscriber DOB	SSN
Subscriber's Employer	Phone	Relationship to Patient

Emergency Contact

Name	Relationship	Phone

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Patient Name: _____

MEDICAL HISTORY

Please **check** any of the following medical conditions that you currently have or have had

○ Diabetes ○Anemia ○High Cholesterol○Hypertension ○ Heart condition ○Blood clots ○ Thyroid

○ Seizures ○ Cancer ○ Glaucoma ○ Arthritis ○COPD ○ Sleep Apnea ○Stroke ○ Kidney disease

Other: _____

_____

_____

SURGICAL HISTORY

Please list you past surgeries or procedures you have had and date of procedures

1._____ year _____

2._____ year _____

3._____ year _____

4. _____ year _____

5._____ year _____

6. _____ year _____

FAMILY HISTORY

Diabetes	○ brother ○ sister ○ mother ○ father ○ grandmother ○ grandfather
Heart problems	○ brother ○ sister ○ mother ○ father ○ grandmother ○ grandfather
Hypertension	○ brother ○ sister ○ mother ○ father ○ grandmother ○ grandfather
Stroke	○ brother ○ sister ○ mother ○ father ○ grandmother ○ grandfather

Cancer who had it and what type: _____

Other: _____

HEALTH MAINTENANCE

Please note the year you had following procedures:

Vaccine: Influenza (year) _____ Pneumonia (year) _____ Zoster (year) _____ Tdap/tetanus (year) _____

Colonoscopy (year) _____ Mammogram (year) _____ Bone density (year) _____

Patient Name:_____

Stress test (year) _____ Eye exam (year) _____ Diabetic foot exam (year) _____

SOCIAL HISTORY

Marital Status: ○ Single ○ Married○Divorced○Widow(er)

Children:○ Boy(s) Age(s) _____ ○ Girl(s) Age(s) _____

Working: ○ Unemployed ○ Retired ○ Disability

Tobacco: ○ Never ○ Quit ○ Present _____ cigs/pack per day. _____ Years of smoking

Caffeine use:○ Never○ Weekends ○ daily

Alcohol: ○ Never ○Past○ Social ○ Weekends ○ daily what type: _____

Illicit Drug ○ No ○Yes

RISK FACTORS

Have you had a blood transfusion? Y N

Do you have a healthy diet? Y N

Do you have pets? Y N

Do you have "End of Life" directives? Y N

Do you Exercise ○ Sometimes ○ regularly ○ Never

MEDICATIONS

Please list all the medications you are taking including over the counter medications (note dose and how often)

1._____ 2._____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

ALLERGIES

1._____ 2._____

3._____ 4._____

Please list the specialist you see

Name: _____ Reason: _____

Name: _____ Reason: _____

Please list your pharmacy: _____

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PATIENT INFORMATION AND OFFICE POLICIES

The following is a summary of our office policies that we have instituted in order to provide our patient with quality care.

Your cooperation with these policies is necessary in order for our office to provide you and your family with quality medical care.

1. Our office hours are Monday – Friday 8:00-5:00 and Saturday from 8:30-1:00 (we are close from 1:00-2:00 for lunch).
2. Appointments are required.
3. Payment is due at the time of service.
4. We accept the following types of payment: cash, personal checks, Visa, MasterCard, American Express, debit cards and money orders.
5. There is a fee of$100.00 for returned check.
6. If one check is returned within a 6 month period we will no longer accept personal checks from you.
7. Any account that is over 90 days past due will be turned over to an outside collection agency.
8. All missed appointments will incur a **$ 25.00 missed appointment fee**.
9. All missed **physical appointments will incur a $50.00 missed appointment fee.**
10. It is the patient's responsibility to provide the office with accurate insurance information.
11. If your insurance company denies a claim for any reason the patient will be responsible for the charges.
12. The Virginia State law allows us to charge for copying medical records, the patient is responsible for these fees.
13. Prescription refills are handled during regular office hours only. No request will be honored after hours, on the weekends, or holidays. Our office requires 24 hour notice for ALL medication refill requests.
14. No medication or narcotics of any kind will be prescribed over the phone; the health care provider must see the patient.
15. There is a 48-hour turnaround time for ALL referrals. Some referrals may take longer to obtain depending on the insurance company's requirements.
16. No referrals are given over the phone. The health care provider must see the patient to evaluate their condition before a referral is given.
17. The patients that are given a referral must contact our office with the date and time of their visit or procedure, as well as the physician's information
18. Our office will attempt to contact the patient by phone with all the results, regardless of what the result is. Please allow our office 5-7 days to contact you after you have the test done**. If you have a test done or have not heard from the office within 7 days please contact us.**
19. Our office will make every attempt to get your claims paid by your insurance company, if the claim has not being paid within 90 days it will the patient's responsibility to pay for the visit.

I certify that I understand and agree with the above policies. I also certify that the information I have given is correct to the best of my knowledge.

_____ _____ ___/___/___ ___/___/___

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the notice of private Practices.

_____	_____	____/____/____
Patient Name	Signature	Date

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: ____/____/____ Attempt: _____

Staff Name: _____

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AUTHORZATION TO RELEASE INFORMATION

Patient Name: _____ DOB:____/____/____ SSN_____

Address: _____ Telephone: _____

I hereby authorize and request Dr. Al-khateeb, M.D. and/or her staff o release any and all information regarding my medical care, treatment, test results and or diagnosis to:

Authorize Receivers Name: _____

Address: _____ Telephone: _____

I understand that his disclosure may include information regarding drug and alcohol abuse. I further understand that this disclosure may include information regarding an illness of a sensitive nature such as: psychiatric records, HIV information,etc.

I understand that I may rescind this agreement by notifying Dr. Al-khateeb, M.D. and/or her staff in writing.

I have read and understand this authorization will allow Dr. Al-khateeb, M.D. and/or her staff to discuss my medical care with the above person(s).

Patient signature: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Deana Al-Khateeb, M.D.
Harriet Greenfield, N.P.
Monica Taylor, F.N.P

Ridgeview Internal Medicine

Phone: 703-494-4116
Fax: 703-497-0051

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth_____

Phone: _____ Address: _____

City/State/Zip: _____

I request and authorize:

Health Care Provider Name: _____

Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

release healthcare information of the patient named above to:

Name: Ridgeview Internal Medicine Address: 2000 Opitz Blvd City/State/Zip: Woodbridge VA, 22191

Phone: 703-494-4116 Fax: 703-497-0051

This Request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

☐ All Healthcare Information

☐Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, wether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____