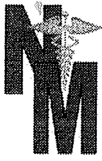

Nokesville Medicine
Patient History

Scanned ☐

Name:________________________ Age______ Gender M / F Birthdate___/___/___

Medications (please list ALL current medications and dosages, including over-the-counter medications:

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________

Medical History
(please list all – e.g. Diabetes/Hypertension)
1.____________________
2.____________________
3.____________________
4.____________________

Surgical History
(e.g. Pregnancies/appendix/gallbladder)
1.____________________
2.____________________
3.____________________
4.____________________

Allergies:
1.____________________
2.____________________
3.____________________
4.____________________

Social History:
Alcohol Consumption (average per week):__________
Drug Use:____________________
Caffeine (average per week):__________
Smoker Y / N (if yes, ______ per day)
Married / Divorced / Single / Widowed
Exercise (average per week)________

Family Medical History (primary relatives)

Maternal Side
1.____________________
2.____________________
3.____________________
4.____________________

Paternal Side
1.____________________
2.____________________
3.____________________
4.____________________

OFFICE USE ONLY

PATIENT VITALS:

BP__________ HR__________ Height:__________

Temp__________ RR__________ Weight:__________

LMP__________ O_2__________

Tetanus Booster__________

Notes

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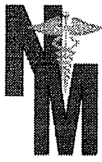
Bill Barrere, M.D.



Nokesville Medicine
Registration Form

REGISTRATION FORM

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PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐Mr. ☐Miss ☐Mrs. ☐Ms.
Marital Status (Circle One): Single / Mar / Div / Sep / Wid	Email:	Birth Date: / /	Age:	Sex: ☐ M ☐ F ☐ Other
Race (Circle One): Caucasian/ African American/Asian/Other	Ethnicity (Circle One): Hispanic or Latino/ Not Hispanic or Latino/ Other/ Do Not Wish to Disclose	Preferred Language:
Street Address:	Apt./Unit No.	Home Phone: ☐Preferred
City:	State:	Zip Code:	Cell Phone: ☐Preferred
Occupation:	Employer:	Employer Phone: ☐Preferred
Other Family Members seen here:		
Preferred Pharmacy:	Location:	Phone Number:

We make every effort to reach our patients in regards to their medical information. Nokesville Medicine would like to insure that your medical information is properly protected as required by HIPAA guidelines. In the event that you are not available, please list names and phone numbers for those individuals with whom we may discuss your medical information. We will not leave messages containing sensitive health related information.

1. ______________________ 2. ______________________ 3. ______________________

INSURANCE INFORMATION

Person Responsible for Bill:	Birth Date: / /	Address (if different than above):	Home Phone:

Is this person a patient here? ☐Yes ☐No

Occupation:	Employer:	Employer Address:	Employer Phone:

Name of Primary Insurance:

Subscriber's name:	Birth Date: / /	Member ID/ Policy #:	Group #:	Co-pay: $	

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary Insurance (If applicable):	Subscriber's name:	Member/ Policy #:	Group #:

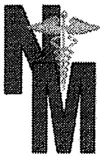
Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient :	Home Phone:	Other Phone:

The above information is true to the best of my knowledge. I authorize Nokesville Medicine to provide medical treatment. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Nokesville Medicine or my insurance company to release any information required to process my claims.

Patient Signature:______________________ Date:______________________



Nokesville Medicine

AUTHORIZATIONS

I authorize Nokesville Medicine, its doctors and/or staff, to leave messages regarding my medical appointments, medical conditions, test results, etc. with the following people:

NAMES

____

____

____

WHERE MAY WE LEAVE VOICE MAIL MESSAGES?

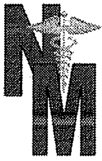
HOME? _______ YES _______ NO _______-_______-__________

WORK? _______ YES _______ NO _______-_______-__________

CELL? _______ YES _______ NO _______-_______-__________

By signing below, I understand that Dr. Barrere does not routinely do pain management. If I require long-term pain medications, I will be referred out to a pain management specialist

____________________________________ ____________________
SIGNATURE OF PATIENT, INSURED OR BENEFICIARY DATE



Nokesville Medicine

Appointment Reminder Authorization

As a courtesy, our office utilizes text, Email, and phone to confirm appointments and send appointment reminders. If you do not wish to receive theses services please indicate below.

**text msg rates may apply

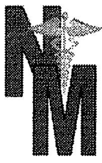
_______YES, I would like reminders

Check all that apply

___ text
___ phone
___ Email
___ All of the above

_______NO, please do not send me reminders

Signature ______________________________ Date ___________



Nokesville Medicine

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: ______________________________________

Date of birth:____

Patient Signature: ___________________________________

Date:______________________

Please list the people with whom we may discuss your medical or appointment information:

Name	*Relationship*	*Contact Number*
Name	*Relationship*	*Contact Number*
Name	*Relationship*	*Contact Number*
Name	*Relationship*	*Contact Number*

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Bill Barrere, M.D.

Nokesville Medicine

SPECIAL FEES

Please be aware that we may charge special fees for certain services, such as copying records, phone consultations, completion of certain forms, letters etc.

Acknowledgement

I have read, understand, and agree to adhere to this financial policy.

____
Signature of patient/guarantor

____
Date

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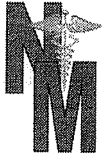
Bill Barrere, M.D.



Nokesville Medicine, PC
No Show Policy

Nokesville Medicine has a policy for canceling appointments.

We understand that unforeseen circumstances arise and it is sometimes necessary to cancel a scheduled appointment. We only ask that adequate notice be given, allowing the appointment to be offered to another patient.
The following policy has been established to best serve all patients and the practice.

24 Hour Advance Notice Required

There is a 24 hour notice required for appointment cancelations. Please leave a voice mail or send an email - to frontdesk@nokesvillemedicine.com - if outside normal office hours.

First NoShow/Late Cancelation

Accidents happen and we all forget at times.

Second NoShow/Late Cancelation

There will be a $20 missed appointment fee applied to the patient's account, payable at the time of their next office visit.

Third NoShow/Late Cancelation

A $20 missed appointment fee will be applied to the patient's account, and the patient may be prevented from scheduling an appointment.

Fourth NoShow/Late Cancelation

Unfortunately, the patient will no longer be seen at Nokesville Medicine.

Acknowledgement

I have read, understand, and agree to adhere to this office policy.

____
Signature of patient/guarantor

____
Date