Nokesville Medicine, PC
Patient History

Name: ____________________ Age: ______ Gender: ________ Birthdate: __________

Medications (List ALL current medications and dosages, including over-the-counter medications)

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

Medical History
(List all – e.g. diabetes, hypertension, seasonal allergies)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Surgical History
(List all surgeries – e.g. appendix, wisdom teeth)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Allergies
(List all medication and your allergic response to each)

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Social History

Alcohol Consumption (avg per week): ________ Do you smoke? # per day ________

Drug Use: ________ If Yes, how long? ________ Marital Status ________

Caffeine Consumption (avg per week): ________ Exercise (hrs per week): ________ Activity ________

Family Medical History

Maternal Side

Mother: ______________________

Mom's mom: ______________________

Mom's dad: ______________________

Siblings: ______________________

Paternal Side

Father: ______________________

Dad's mom: ______________________

Dad's dad: ______________________

Siblings: ______________________

OFFICE USE ONLY

PATIENT VITALS:

BP ________ Height ________ SpO_2 ________

HR ________ Weight ________ LMP ________

RR ________ Temp ________ Last tetunus ________

Nokesville Medicine, PC
Registration Form

PATIENT INFORMATION					
Patient's Last Name:	First:	Middle:	SSN:		
Marital Status:	Email:	Birthday:	Age:	Sex:	
Race:	Ethnicity:	Preferred Language:			
Street Address:	Apt/Unit. No.	Home Phone: Preferred ☐			
City:	State:	Zip Code:	Cell Phone: Preferred ☐		
Occupation:	Employer:	Work Phone: Preferred ☐			
Other Family Members seen here:					
Preferred Pharmacy:	Location:	Phone Number:			
We make every effort to reach our patients regarding their medical information. Nokesville Medicine would like to ensure that your medical information is properly protected as required by HIPPA guidelines. If you are not available, please list names and phone numbers for those individuals with whom we may discuss your medical information.					
1.	2.	3.			

INSURANCE INFORMATION					
Person responsible for bill:	Birth date:	Address (if different from above):	Home Phone:		
Is this person a patient?	Yes ☐	No ☐			
Occupation:	Employer:	Employer Address:	Work Phone:		
Name of Primary Insurance:					
Subscriber's name:	Birth Date:	Member ID/Policy #:	Group #:	Copay $	
Patient relationship to subscriber:	Self ☐	Spouse ☐	Child ☐	Other ☐	
Name of Secondary Insurance (If applicable):	Subscriber's name:	Member/Policy #:	Group #		
Patient relationship to subscriber:	Yes ☐	No ☐			

IN CASE OF EMERGENCY			
Name of local friend or relative (not at same address):	Relationship to patient:	Home Phone:	Cell 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 require to process my claims.			
Patient Signature:		Date:	

Nokesville Medicine, PC
Authorizations

Where may we leave voice mail messages?

Home? Yes ☐ No ☐ Phone Number: ______________________________

Work? Yes ☐ No ☐ Phone Number: ______________________________

Cell? Yes ☐ No ☐ Phone Number: ______________________________

Initial: __________

Would you like reminders for your appointments? Yes ☐ No ☐

If Yes, check all that apply: **Text ☐ Phone ☐ Email ☐ ALL ☐

** Data rates apply

Initial: __________

Privacy Practices Acknowledgement

https://drive.google.com/file/d/1PoJdZSM3Z3AvFFOyTnCRRTmLnhPLhUEi/view?usp=sharing

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

Initial: __________

Pain Management Acknowledgement

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

Initial: __________

Special Fees

I am aware that there may be special fees for certain services as described below. All charges will be discussed with me before they are incurred. An example of such fees are:

- Medical records (faxed to a mutual provider) – no charge
- Medical records delivered to patient – 10¢/page
- FMLA forms - $20/form
- Adoption forms - $10/form
- Letters of Medical Necessity - $10/letter

Initial: __________

Patient Signature: ____ Date: ______________

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