Anita M. Maybach, MD
Autumn Hernandez, PA-C

381 Stuyvesant St, Ste 1
Warrenton, VA 20186

(540) 347-4410 (P)
(540) 347-4456 (F)

Patient Registration (Please Print)

Patient's Name_____

DOB: _____/_____/_____

SSN: _____/_____/_____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Employer: _____phone_____

Home Phone: _(_____)_____ cell phone_____

Marital Status (circle): Mar Div Sep Wid Single

Name of person financially responsible: _____

Primary Insurance: _____

Subscriber Number: _____

Subscriber Name: _____

DOB: _____/_____/_____

SSN: _____/_____/_____

Secondary Insurance: _____

Emergency Contact:

Phone: _(_____)_____

Relationship: _____

If patient is a minor, who may authorize treatment? _____

May we leave non-critical information on your answering machine? YES NO

Exceptions:_____

Name of your local pharmacy (choose only 1, excluding mail away pharmacy)

_____

AUTHORIZATIONS

I authorize Anita M. Maybach, MD and all persons acting as agents thereof, as well as all medical personnel to who I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to me or my minor child/conservatee.

Patient/Parent/Guardian Signature:_____
Date:_____

I hereby give authorization for present and future payment of insurance benefits to be made directly to Anita M. Maybach, MD and any assisting practitioners for services rendered. I understand that I am responsible for payment of all medical services rendered, regardless of whether or not such services are a covered benefit of my insurance. I agree to pay all co-payments and deductibles at the time of service. I hereby authorize release of information necessary to secure the payment of benefits.

Patient/Parent/Guardian Signature: _____ Date: _____

PRIVACY

We are committed to protect your health care information and will not release information to anyone without your consent. Please list any people whom we have your permission to discuss appointment, insurance or medical information. Do we have your permission to release information to anyone other than yourself? YES NO

Name:_____
Relationship to you:_____

Name:_____
Relationship to you:_____

Name:_____
Relationship to you:_____

lease fully complete this form: your answers help your provider understand your medical concerns & conditions

atient's Name_____ Date of Birth_____

eason for Today's Visit_____

llergies/Reactions to Medicines:_____

urrent Medications: Prescription, non-prescription medicines, vitamins and supplements.

Medication	Dose (e.g. Mg/pill)	How many time/day	When Started

ersonal Medical History

YES/DATE	MEDICAL PROBLEM		YES/DATE	MEDICAL PROBLEMS
	Irregular Heart Beat			Kidney Stones
	Congestive Heart Failure			Kidney Disease/Infections
	Blood Clot			Breast Disease
	High Cholesterol			Fracture, which bone(s):
	High Blood Pressure			Arthritis
	Heart Attack			Gout
	Heart Murmur			Stroke
	Asthma			Dementia
	Skin disease, type:			Cancer, type:
	Pneumonia			HIV
	Pulmonary Embolism			STDs
	Tuberculosis			Blood Transfusion
	Sleep Apnea			Anemia
	Gall Stones			Bleeding Disorder
	Liver Disease/Hepatitis			Seasonal Allergic
	Hemorrhoids			Emphysema/Chronic Bronchitis
	Diabetes Type 1 (Childhood onset)			Stomach Ulcer
	Diabetes Type 2 (Adult onset)			Problems During Pregnancy
	Diverticulitis			Thyroid Disease (High/Low)
	Ulcerative Colitis/Crohn's			Depression
	Heart Burn/Reflux			Anxiety

Further explanation for "yes" answers:_____

List any Hospitalizations (reason & date): _____

Woman's Gynocological Records: Sexual Activity: Yes / No Contraceptive Method:_____

Date of First Period:_____ Date of Last Period:_____ menopausal: no / yes date:____

# of pregnancies:____ # of deliveries:____ # of miscarriages:____ # of abortions:____

Health Maintenance: When were your most recent screen tests?

Cholesterol Screening?_____ Results?_____ PSA (Prostate) ?_____ Results?_____

Sigmoidoscopy?_____ Results?_____ Stool Test for Blood?_____ Results?_____

Immunizations: Please indicate the date of your most recent: Tetanus_____ Pneumovax (Pneumonia)_____

Social History: Tobacco Use: Cigarettes___ Never ____ Quit: Date_____ Current Smoker: packs/day_____ # years____

Socioeconomics: Marital Status S M D W Other:_____ Spouse/Partner's name:_____

Children: Names, Ages_____

Occupation:_____Employer:_____ Years of Education/Highest Degree:_____

Sexual Activity: Sexually active: Yes / No / Not Currently Current sex partner is: male / female

Exercise: Do you exercise regularly? No / Yes, What Kind: _____ How long:_____How often:_____

Surgical History: Have you had any of these surgeries? Please use the space below for further information if needed:

YES/DATE	SURGERY		YES/DATE	SURGERY
	Appendectomy			Gallbladder
	Join Arthroscopy, Joint:			Joint Replacement, Joint:
	Heart Catheterization			Back Surgery
	Abdominal Surgery			Prostate
	Neck Artery			Vasectomy
	Open Heart/Bypass			Tonsillectomy
	Hemia			Adenoidectomy
	Biopsy (of what?)			Cosmetic
	Broken Bone Repair			C-Section
	Sinus			Hysterectomy: Vaginal / Abdominal
	Lasik R or L			Ovaries out? Yes / No?
	Cataract R or L			Other:
	Other:			Other:

Family History: Please indicate with a check family members who have had any of the following conditions:

Condition	Mom	Dad	Sis	Bro	Daug	Son	Mom's mom	Mom's dad	Dad's mom	Dad's dad	Mom's Sis.	Mom's Bro	Dad's Sis	Dad's Bro
Alcoholism														
Anemia														
Anesthesia Problems														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding Problems														
Cancer Breast														
Cancer Colon														
Cancer Melanoma														
Cancer ovary														
Cancer Prostate														
Heart Attack														
Birth Defects														
Depression														
Diabetes (Ty 1)														
Diabetes (Ty 2)														
Eczema														
Food Allergies														
Other genetic disease														
Hay Fever														
Hearing Problems														
High Cholesterol														
High blood pressure														
Immunosuppressive dis.														
Kidney disease														
Mental retardation														
Osteoporosis														
Epilepsy														
Stroke														
Substance abuse														
Thyroid disorder														
Smoking														
Tuberculosis														
Other:														
Other:														