Bay West Endocrinology Associates
REGISTRATION FORM
(Please print)

☐ Dr. Tyzack ☐ Dr. Horowitz ☐ Dr. Khan ☐ Dr. Pao ☐ Dr. Davidson ☐ Dr. Mindel ☐ Dr. Peng ☐ Dr. Haber
☐ Hyeon Joo Lee, NP ☐ Sommer Lloyd, NP ☐ Jennifer Malloy, PA-C

PATIENT INFORMATION

Patient's last name: First: Middle:		Date of Birth / /	Age:	☐Mr. ☐Ms. ☐Mrs. ☐
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security No.: - -		Preferred Pronouns: ☐ She /Her / Hers ☐ He / Him / His ☐ They/Their/ Them ☐ Other:
Legal Gender: ☐ Male ☐ Female	Gender Identity:			
Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other				
Street address:	Home Phone: ( ) -		Cell Phone: ( ) -	
City:	State:	Zip:	Email address:	
Referring provider:	Phone #		Fax #	

INSURANCE INFORMATION

(Please provide your insurance card to the front desk at each appointment)

Is this patient covered by medical insurance? ☐Yes ☐ No			
Occupation:	Employer:	Employer Address:	Employer phone no.:
Primary Insurance:	Address:		Ins. Phone # ( ) -
Policy/Member ID:	Group #		Specialty Co-payment $
Policy holder's Name:	Policy Holder's SSN - -		Policy holder's Date of Birth:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Secondary Insurance (if applicable):	Address:		Ins. Phone # ( ) -
Policy/Member ID:	Group #		Policy holder's Date of Birth: / /
Policy holder's Name:	Policy Holder's SSN		
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

OFFICE FEES NOT BILLED TO INSURANCE COMPANY

Cancellation Fee:	**Follow up fee: $25.00-$45.00**	**New patient/Procedure: $100.00 fee**
(Less than 24 business hours' notice)	**($25.00 base fee, $10.00 per each additional appointment type)**	
Medical Record Copies:	**$22.88 + $0.73 per page**	**$40.00 flat fee for CD**
Yearly Administrative fee:	**$15.00 per year**	
Form Fees: (If administrative fee is not paid)	**$15.00 for one page**	**$30.00 for multiple pages**
Billing fee for copays not paid at Time of service:	**$10.00**	
Collections fee on accounts 84 past due date	**$20.00**	

Appointment Date:_____ Time:_____

Original Date:
Dates Revised:

BAY WEST ENDOCRINOLOGY ASSOCIATES
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Yes ☐ No					
	Details:					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No

Employer Name:	Occupation:

Review of Systems

Patient Name:_____ Date:_____

Had a flu shot this year?	No	Yes

Had a pneumonia shot?	No	Yes

Name of Primary Care Physician_____

Phone Number_____

Please indicate below systems you are currently experiencing:

General, constitutional:

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes and Vision

Eye disease or injury	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

Ears, Nose, Throat

Hearing Loss or ringing in ears	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores or bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Heart and Cardiovascular

Palpitations	No	Yes
Chest Pain	No	Yes
Swelling in legs, or feet	No	Yes
High Blood pressure	No	Yes
High Cholesterol	No	Yes

Respiratory

Frequent coughing	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of Appetite	No	Yes
Heartburn	No	Yes
Nausea or vomiting	No	Yes
Constipation or diarrhea	No	Yes
Blood in stool	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes

Skin

Rash or itching	No	Yes
Change in skin, hair, or nails	No	Yes

Musculoskeletal:

Joint pain, stiffness or swelling	No	Yes
Muscle pain, cramps or weakness	No	Yes
Back or Neck pain	No	Yes
Osteoporosis	No	Yes
History of Fractures	No	Yes
Last DXA scan date		

Neurological

Frequent or recurrent headaches	No	Yes
Light headedness or dizziness	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Anxiety or Depression	No	Yes
Sleep problems	No	Yes

Endocrine

Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Change in shoe or glove size	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Transfusion	No	Yes

Male Patients:

Prostate Problems	No	Yes
Erectile dysfunction	No	Yes
Breast enlargement or discharge	No	Yes

Female Patients

Irregular periods	No	Yes
Breast pain/lumps/discharge	No	Yes
Last Menstrual Period		
Menopause Date		

Signed by patient: _____

Privia Health
950 N Glebe Road, Suite 700
Arlington, VA 22203

MY PREFERRED CONTACTS

Patient Name: _____ Date of Birth: _____

Address: _____
Street City / State / Zip

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. **Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

1)Full Name:_____ Relationship:_____
_____ _____
Telephone:_____ Email:_____
_____ _____

2) Full Name:_____ Relationship:_____
_____ _____
Telephone:_____ Email:_____
_____ _____

3) Full Name:_____ Relationship:_____
_____ _____
Telephone:_____ Email:_____
_____ _____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature:_____ Date:_____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVIA MEDICAL GROUP

AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ **Email:** _____

➔ **Signature:** _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent

Name and Relationship of Person Signing, if not Patient: _____

****Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.***