PATIENT HEALTH HISTORY

Today's Date_____

Name_____ DOB_____ Age_____

Weight ____ lbs **Height** ___ft ____inches Marital Status_____

Have you or anyone in your family seen Dr. Gavin before? Yes No
If yes, whom?_____
What are you being seen for?_____ (please specify Right or Left)
Date of Onset_____ How did this Occur?_____
Referred By?_____ Primary Doctor?_____
Job/Occupation _____ Employer _____
Do you participate in any sports or exercise of any kind? Yes No
If Yes, Please explain_____
_____
Please list any **Current** medical problems_____
_____
_____
Please list any **Current** medications you are taking:_____
_____
_____
What Pharmacy can we send short term prescriptions to if necessary?
Pharmacy name _____ City _____
Please list any **Previous** surgeries that you have had: _____
_____
Allergies : _____

Do you: Smoke: Yes or No Alcohol: Yes or No Recreational Drugs: Yes or No

Patient History : Please check if you have had any of the following conditions or medical problems

___ Hiatal Hernia	___ Seizures	___Irregular Heart Beat	___ MI (heart attack)
___Ulcer	___ Migraines	___ High Blood Pressure	___ PVD/DVT (clots)
___Diabetes	___ Syncope	___ Angina/ Chest Pain	___ MVP
___Thyroid	___ Asthma/ Emphysema	___Rheumatoid Disorders	___ Skin Disorders
___ UTI	___Bronchitis/Pneumonia	___ Congestive Heart Failure	

Please list any Family medical history: _____
_____

* If you would like to be on our patient email list and receive emails for special events or special information updates, please list your email address below:

_____

YOU CAN GET ACCESS TO THIS INFORMATION

Treatment: Your health information may be used by staff members or disclosed to other healthcare providers for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of an evaluation will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff member.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or credit card companies that you may use to pay for the services. For example, your health plan may request and receive information on dated of service, the service provided and the medical condition being treated.

Health Care Operation: your health information may be used as necessary to support day to day activities and management of this office. For example, information on the service you receive may be used to support budgeting and financial reporting and activities to improve quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Other uses disclosures require your authorization: Disclosure of your health information or its use any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or discloser before you notify us of your decision.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your health information
- The right to amend and or submit corrections to your health insurance
- The right to receive an accounting of how and to whom your health information has been disclosed
- The right to receive a printed copy of this notice

OUR HEALTH INFORMATION DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy and practices that are outlined in this notice.

OUR RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by change in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal law, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form or request access to your records by contact the Company's Privacy Office.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated you can contact the Company by sending a letter outlining your concerns to:

Dr. Matthew Gavin
224D Cornwall Street NE, Suite 204
Leesburg, VA 20176

You may also file a written complaint with the office of Civil Rights

I acknowledge that I have been informed of the Notice of Privacy Practices by the office of Dr. Matthew Gavin.

_____ _____

Patient Signature or Authorized Representative Date