DR. ROXANNE DIETZLER, PC
D. O.
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PATIENT INFORMATION

First Name: _____ M.I.____ Last Name: _____Suffix____

SSN: _____ D.O.B: _____

Please Circle or complete other:

MARITAL STATUS	GENDER	RACE	ETHNICITY	PRIMARY LANGUAGE
Single	Male	American Indian	Hispanic	English
Married	Female	Asian	Non-Hispanic	Chinese
Divorced	Trans	Black/ African American	Unknown	Japanese
Widowed	Neutral	Caucasian / White		Spanish
Other:	Other:	Other:	Other:	Other:

Street Address:_____

City: _____ State: _____ Zip:_____Email:_____

Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Primary Phone Contact: Cell Work Home Secondary Contact: Cell Work Home

Family Doctor's Name : _____ Location (City):_____

Work Status – please circle: Full Time Student Part Time Student Employed Unemployed

Preferred Pharmacy: _____ Street: _____ City: _____

Reason For Visit: Work Related Injury Work Related Physical Private/Self Pay Visit Other

If work related visit: Name of Company: _____

Date of Injury (if applicable):_____ Where else seen:_____

HIPAA Release: Others your information can be released to. (MUST add names on HIPAA form)

1._____ 2._____

Parental Information for patients under 18:

Parent/Guardian Name: _____ D.O.B:_____

MEDICAL HISTORY: Circle any conditions you have had

Anemia	Asthma	Dermatitis	Gout	Kidney Disease	Migraines	Positive PPD	Stroke
Ankle Injury	Bleeding Disease	Diabetes	Hepatitis	Knee Injury	Neck Pain	Reflux	Sleep Apnea
Anxiety or Depression	Bloody Sputum	Fibromyalgia	Hypertension	Liver Disease	Night Sweats	Shoulder Pain	TB
Arthritis	Cancer	Glaucoma	High Cholesterol	Low Back Pain	Persistent Cough	Seizure	TIA

Are you currently being treated by pain management or have chronic pain? _____ Yes _____ No

Other (Not listed above) :_____

SURGICAL HISTORY AND PROCEDURES: Circle any you have had

Ankle R / L	C Section	Gallbladder	Hernia	Hysterectomy	Knee R / L	Neck	Tonsils
Appendix	Colonoscopy	Heart Stent Bypass	Hip R / L	Tubal Ligation	Low Back	Shoulder R / L	Vasectomy

Other:_____

Daily Medications: _____

_____

Allergies and Reactions (Rash, Swelling, or Difficulty breathing, etc.): _____

_____

Mother ____Alive ___Deceased (Cause)_____ Father ___ Alive ___Deceased _____

Siblings - # Alive _____ # Deceased _____ (Cause)_____

Do you have any family history of: _____ Cancer _____ Diabetes ____ Heart Disease _____

Do you currently use: ____Cigarettes ____Cigars ____Snuff ___Chewing Tobacco ____Vape ___None

How much in a day:_____ How many months/years_____

Have you smoked in the past? _____ Yes _____ No If so, How long and how much _____

Do you drink? ____ Never ____Rarely ____Monthly ____Weekly ____Daily How Much?_____

Vaccines: Have you had a Tetanus shot in the last 10 years? _____Yes _____ (year) _____No

Consent Form: Please initial on the lines below, then print, sign and date at the bottom

____ I hereby give my consent for Dr. Roxanne Dietzler, PC and its representatives to obtain necessary historical information, perform physical examinations, medical evaluations, medical testing, including drug testing (if applicable) and to administer necessary treatment and or medications as may be necessary. I also consent to all treatments as deemed appropriate by the treating physician. I consent to the release of protected health information that is required to carry out treatment and payment for healthcare services performed on my behalf.

____I further attest that a copy of the of the Notice of Privacy Practices is posted on the wall at Dr. Roxanne Dietzler office and that I have been offered a copy, received, read and understand that the Notice of Privacy Practices at this office.

____I understand that in accordance with Section 32.1-45.1 of the Code of Virginia, 1950, as amended, that if during the course of the provision of health care services at Dr. Roxanne Dietzler, PC any staff member or any individual under the direction of Dr. Roxanne Dietzler or any other health care provider is exposed to my bodily fluids in a manner which according to the guidelines of the Center of Disease Control, could potentially transmit human immunodeficiency virus (HIV), Hepatitis B, and/or Hepatitis C that I shall be deemed to have consented to blood testing for infection with HIV, Hepatitis B and C. I further agree to the release of all related blood test results to the person who was exposed.

For patients sent in by their company or Work-Related injuries or Care:

____I realize that this evaluation may be at my employer or future employer's request. I authorize Dr. Roxanne Dietzler, PC to complete tests of examinations on me as may be required by my employer. I understand this may include tests for drug and alcohol use pursuant to an agreement between my prospective or current employer and Dr. Roxanne Dietzler, PC. I understand that the tests may include the procurement and examination of urine, breath, hair and/or blood samples. Further, I understand that a Medical Review Officer not employed by Dr. Roxanne Dietzler, PC may be reviewing the drug test results and that the MRO may contact me.

____I authorize the release of medical information obtained during my evaluation and/or test results to my prospective or current employer. I understand that if I decline to sign this consent and thereby decline to take the test or undergo an examination that has been requested by the employer, that Dr. Roxanne Dietzler, PC will notify the employer. I further understand that if Dr. Roxanne Dietzler, PC is performing these test(s) as a service to the employer or prospective employer and that Dr. Roxanne Dietzler, PC assumes no responsibility for any actions taken by the employer as a result of the examination or test or refusal to consent to the test or examination.

____I consent to the release of protected health information that is required to carry out treatment and payment for the healthcare services performed on my behalf. I understand that this may include, but is not limited to, information such as current and prior medical history, exam results, diagnosis and treatment plans. I further understand that this information may be released to my employer, employers' representatives, insurance companies, nurse case manager and others who may be or become involved with my case. I also consent to all treatments as deemed appropriate by the treating physician and agree to pay for all such services rendered if the claim is work related and denied by the employer or insurance company. If my claim is denied I understand that I will be sent a bill and that payment will be expected at the time the bill is received. I accept responsibility for payments of all charges incurred as well as all collection agency cost and/or attorney's fees. I understand that Virginia Worker's Compensation has specific rules related to HIPAA and medical information that can be found on the Virginia Workers' Compensation website and that these rules and regulations may differ from other HIPPA rules and regulations.

____In certain circumstances it may be necessary for Dr. Roxanne Dietzler, PC to obtain medical information from other physicians, hospitals, laboratories, etc. about medical conditions, illnesses or injuries that may relate to the current condition, illness or injury. By signing below, I authorize the release of this protected health information to Dr. Roxanne Dietzler, PC and understand that the information may be released to my employer, the insurance carrier and/or others who may be involved with my case, case or claim.

For Private Pay Patients:

____I understand that payment is due prior to services rendered and that only cash and credit cards, no personal checks are accepted. I understand that Dr. Roxanne Dietzler, PC does not file nor accept any personal insurance including but not limited to Anthem BC/BS, Optima, Medicare, Medicaid, Tricare, etc. I understand that my insurance company may receive a separate bill for lab work, radiology or specialist services not performed by Dr. Roxanne Dietzler, PC, but ordered for my care.

____I understand that if my child is here for a school or sports physical that Dr. Dietzler is not assuming care for my child and that she will not be taking on the care of my child. No physician – patient relationship is being established for ongoing care.

Patient Name Printed _____ Patient Signature (or Parent if under 18) _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before singing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ Signature of Patient or Legal Representative

_____ Date

_____ Printed Name of Patient

_____ Legal Relationship to the Patient (if required)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give permission to share my health information with:

1.Name_____ Relationship_____ Phone:_____

2.Name_____ Relationship_____ Phone:_____

Consent to email or text for appointment reminders and other healthcare communications.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or portal information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke it.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is:

_____. _____ please initial

The email address that I authorize to receive email messages for appointment reminders and general health information or a portal use is

_____. _____ please initial

____ I decline to receive communications via text ____ I decline to receive communications via email

Revocation Use this area to document revocation of a previous form of communication.

____I hereby revoke my request to receive future appointment reminders or healthcare updates vis text.

____I hereby revoke my request to receive future appointment reminders or healthcare updates via email

Patient signature_____ Date requested_____

Reminder-Keep information to the minimum necessary and encrypt emails and texts whenever possible.