NovaCure Consultants, PC
8101 Hinson Farm Road . Ste 211 . Alexandria, VA 22306
Phone (703)780-2216 . Fax (703)780-9487
Soren Caffey, MD . Yin Wu, MD

PHARMACY: _____

PATIENT INFORMATION

NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____

DATE OF BIRTH:_____ SEX: MALE____ FEMALE____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ RACE: _____ ETHNICITY: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ **EMAIL ADDRESS:** _____

HOME PHONE: (___)_____WORK PHONE: (___)_____CELL PHONE: (___)_____

OCCUPATION: _____ APPT. REMINDER: TEXT_____ EMAIL_____

REFFERING OR PRIMARY DOCTOR: _____ PHYSICIAN'S PHONE: (___)_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

STREET ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: (___)_____ WORK PHONE: (___)_____ CELL PHONE: (___)_____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN INFORMATION (MUST BE COMPLETED)

PLAN NAME: _____ PHONE NUMBER: (___)_____

GROUP #: _____ POLICY #: _____

POLICY HOLDER: _____ SS# OF POLICY HOLDER: _____

HOLDER'S DATE OF BIRTH: _____ RELATIONSHIP: _____

EMPLOYER'S NAME: _____ EMPLOYER'S PHONE: (___)_____

COPAY (YES) _____ (NO) _____ REFERRAL NEEDED: _____

SECONDARY INSURANCE PLAN INFORMATION

PLAN NAME: _____ PHONE NUMBER: (___)_____

GROUP #: _____ POLICY #: _____

POLICY HOLDER: _____HOLDER'S DOB: _____ RELATIONSHIP: _____

This is authorization for *NovaCure Consultants*, to apply for benefits on my behalf and receive any payments for medical services rendered to me by employees of this organization through all insurance plans indicated above or any other plans through which I may receive coverage. I further authorize the release of any necessary medical information for any claim to my insurance carrier or any medical facility to ensure continuity of care. I herby acknowledge that I am fully responsible for payment or the total bill incurred and warrant that I shall comply with all insurance plan guidelines to insure liability for reimbursement of services provided by *NovaCure Consultants*.
In the event that a collection agency becomes involved due to non-payment, I understand that I am responsible for any and all collection and/or legal fees.

SIGNATURE_____ DATE: _____

NovaCure Consultants, PC

Date:

(703)780-2216

NAME:_____ DOB:_____ AGE:_____

HEIGHT:_____ WEIGHT:_____

REASON FOR VISIT:_____

HPI:

Past Medical History:

Hypertension [ ]	Stroke [ ]	Lung disease [ ]
Diabetes [ ]	Stomach ulcer [ ]	Liver Disease [ ]
Heart Disease [ ]	High cholesterol [ ]	Kidney Disease [ ]
Arthritis [ ]	Other: _____	

Past Operations:

Name of operation: Name of surgeon: Month/Year:

Family History: Father- Mother-

Brother- Sister-

Other Family Members-

Social History: Live Alone [ ] With Spouse [ ] With Other family [ ] With Friend [ ]

Smoking: [ ] Packs per day:_____ for_____ years

Alcohol: [ ] Social [ ] Moderate [ ] Heavy [ ] For _____ Year

Other drugs used in the past or present-_____

Type of work most of your life- _____

Ob/Gyn History (Women only): Menstrual Cycle regular- YES NO

Menopause- YES NO If yes, age of menopause___

No. of Children _____

No. of Miscarriages- _____

NAME:_____DOB:_____

Review of systems: Please write the duration of following symptoms after the [ ] in weeks or months or years.

General:

Fever [ ] _____
Chills [ ] _____
Night sweats [ ] _____
Lumps or Bumps [ ]_____
Loss of appetite [ ]_____
Weight [ ] _____
Fatigue [ ] _____
Pain [ ] _____ Location_____

Cardiopulmonary:

Cough [ ]_____
Chest Pain [ ]_____
Blood in Sputum [ ]_____
Swelling of Legs [ ]_____
Shortness of Breath [ ]_____
Phlegm [ ]_____ Color of Sputum_____
Palpitation [ ]_____

Gastro-intestinal:

Nausea [ ]_____
Vomiting [ ]_____
Heartburn [ ]_____
Difficulty swallowing [ ]_____
Gaseousness [ ]_____
Blood in stool [ ]_____
Abdominal pain [ ]_____
Constipation [ ]_____
Diarrhea [ ]_____
Abdominal Distension [ ]_____
Dark stool [ ]_____
Pain in B.M [ ]_____

Genito- urinary:

Burning with urination [ ]_____
Difficulty urinating [ ]_____
Incontinence [ ]_____
Blood in urine [ ]_____
Frequent urination [ ]_____
Discharge [ ] _____

Nervous System:

Headache [ ]_____
Dizziness [ ]_____
Numbness [ ]_____
Weakness [ ]_____
Impaired vision [ ]_____
Impaired hearing [ ]_____
Impaired memory [ ]_____

Musculoskeletal:

Backache [ ]_____
Muscle ache [ ]_____
Joint pains [ ]_____
Joint Swelling [ ]_____
Joint stiffness [ ]_____

Skin:

Rash [ ]_____
Itching [ ]_____
Bruises [ ]_____
Ulcers [ ]_____

Other:

Nose Bleed [ ]_____
Fainting [ ]_____
Bleeding gums [ ]_____

Medication:

NAME: DOSE HOW OFTEN

ALLERGIES: