Sally A McFarland MD, PC

4001 Fair Ridge Dr. Suite #306

Fairfax, VA 22033

Phone: (703) 539-8601 Fax: (703) 539-8578

**PATIENT INFORMATION**

Patient’s last name: First Name: MI: .

Street Address: .

City: State: Zip: .

Email: .

Social Security #: Sex: M or F Date of Birth: .

Home Phone: Work Phone: Mobile Phone: .

Occupation: Employer: .

Employer’s Address: City: State: Zip: .

Marital Status: Spouse’s Name (if applicable): Work Phone: .

In case of emergency notify: Relationship to Patient: .

Home Phone: Work phone: Mobile phone: .

**POLICY HOLDER/GUARANTOR:** (Please fill out if someone other than the patient is the policy holder.)

Last name: First Name: MI: .

Street Address: .

City: State: Zip: .

Social Security #: Date of Birth: .

Occupation: Employer: .

Employer’s Address: City: State: Zip: .

Home Phone: Work phone: Mobile phone: .

**INSURANCE INFORMATION:**

Primary Insurance Company: .

Insurance Co. address: (on back of card) .

City: State: Zip: .Phone: .

ID: Group Policy#: .

Name of Policy holder: Relationship to patient: .

**SECONDARY INSURANCE:**

Secondary Insurance Company: .

Insurance Co. address: (on back of card) .

City: State: Zip: .Phone: .

ID: Group Policy#: .

Name of Policy holder: Relationship to patient: .

**Patient Signature**: **Today’s date**: .

*.(Please present your insurance card along with this form to insure that our records will be correct. Please notify this office promptly of any changes in address, phone, or information.)*

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Patient name: Today’s date: Date of Birth: Height: .

Are you allergic to any medicines? Yes No (if so, please list them below)

Are there any medicines you cannot take because of side effects? Yes No (if so, please list them below)

Please list medicines you are currently taking and dose:

**Prescriptions**:

**Over the counter** (e.g. vitamins, herbal, alternative etc.)

Please List any surgeries you have had, and the year:

Please list medical problems that you have: (for example, allergies, high cholesterol, etc.)

Do you smoke now: Yes No (if no, did you smoke in the past: Yes No .)

Do you drink alcohol: Yes No (if yes, how often and how much)

Have you used illicit drugs now of in the past (e.g. marijuana, cocaine) Yes No .

Have you ever used injected illicit drugs? Yes No .

Please fill out your family history for parents, siblings, and/or children. Please indicate their major health problems, and whether they are living or deceased.

**Mother**:

**Father**:

**Siblings**:

**Children**:

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New government regulations require that we collect the following information.

Hispanic: Non-Hispanic: .

Preferred Language: .

Race:

* African or African/American:
* Asian or Asian/American
* Native American of Native Alaskan
* Hawaiin or other Pacific Islander
* Other: .

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, , have been made available a copy of Dr. McFarland’s Notice of Privacy Practices.

. . . .

 Signature of Patient Today’s Date