VIRGINIA SURGICAL SERVICES
703-594-1583 | Secure fax 571-601-2937

Patient fax cover sheet

Use this page when sending completed forms or records by fax.

DESTINATION

Secure fax: 571-601-2937

Virginia Surgical Services | Suite 205B | Fairfax, Virginia

SENDER AND TRANSMISSION

Patient or sender name

Best callback number

Patient date of birth

Date sent

Total pages

Appointment date, if known

CONTENTS

- [ ] New patient intake packet
- [ ] Medication and allergy list
- [ ] Prior medical records
- [ ] Imaging or laboratory reports
- [ ] Insurance information
- [ ] Other

Notes for the office

CONFIDENTIALITY NOTICE

This fax may contain confidential health information intended only for Virginia Surgical Services.
If you sent it in error, call the office promptly. Fax is not monitored for emergencies. Call 911 for an emergency.

New patient registration

Complete every section that applies. Please print clearly if completing by hand.

Patient name | **Date of birth** | **Medical record no. (office use)**

PATIENT INFORMATION

Legal name | **Preferred name** | **Pronouns (optional)**

Street address

City | **State** | **ZIP** | **Preferred language**

Mobile phone | **Other phone** | **Email**

EMERGENCY CONTACT

Name | **Relationship** | **Phone**

COMMUNICATION AND ACCESS

- ☐ May leave a voicemail identifying the practice
- ☐ Do not leave detailed voicemail
- ☐ Patient portal preferred when available
- ☐ Interpreter or communication help requested

Accommodation or communication need

Insurance and referral information

Coverage varies by plan and service. The office will verify what it can before scheduled care.

Patient name

Date of birth

Medical record no. (office use)

PRIMARY INSURANCE

Plan / insurer

Member ID

Group number

Subscriber name

Subscriber DOB

Relationship to patient

SECONDARY INSURANCE, IF APPLICABLE

Plan / insurer

Member ID

Group number

REFERRAL AND CURRENT CLINICIANS

Referring clinician / practice

Phone

Primary care clinician

Phone

Other specialists involved in this care

ACKNOWLEDGMENT

I confirm that the information I provided is accurate to the best of my knowledge. I understand that coverage, authori zation, and benefits do not guarantee payment, and that separate professional, facility, anesthesia, pathology, labora tory, imaging, or other charges may apply.

Patient / representative signature

Date

Medical and surgical history

Mark current or past conditions and add details where requested.

Patient name

Date of birth

Medical record no. (office use)

REASON FOR VISIT

Main problem, symptoms, and what you hope to address

HEALTH HISTORY

- ☐ Heart disease / heart attack
- ☐ High blood pressure
- ☐ Abnormal heart rhythm
- ☐ Heart failure
- ☐ Stroke / TIA
- ☐ Blood clot / DVT / PE
- ☐ Bleeding disorder
- ☐ Asthma / COPD
- ☐ Sleep apnea / CPAP
- ☐ Diabetes
- ☐ Kidney disease / dialysis
- ☐ Liver disease
- ☐ Cancer
- ☐ Seizure disorder
- ☐ Reflux / ulcer
- ☐ Thyroid disease
- ☐ Arthritis / mobility limitation
- ☐ Anxiety / depression
- ☐ Current infection / fever
- ☐ Pregnancy possible

Details, dates, and treating clinicians

PRIOR SURGERY AND HOSPITALIZATION

Procedure / hospitalization, date, facility, and complication if any

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Anesthesia and procedure history

This information helps determine whether an office, ambulatory center, or hospital is the right setting.

Patient name

Date of birth

Medical record no. (office use)

PRIOR ANESTHESIA

- ☐ Never had anesthesia
- ☐ Difficult airway / intubation
- ☐ High fever / malignant hyperthermia
- ☐ Severe pain-control problem
- ☐ Severe nausea or vomiting
- ☐ Awareness during anesthesia
- ☐ Prolonged sedation
- ☐ Family anesthesia complication

Details

CURRENT FUNCTIONAL STATUS

- ☐ Can climb two flights of stairs without stopping
- ☐ Chest pain with activity
- ☐ Uses CPAP / BiPAP
- ☐ Cannot climb two flights without stopping
- ☐ Shortness of breath with usual activity
- ☐ Pacemaker / defibrillator / implanted device

Details and limitations

TOBACCO, ALCOHOL, AND OTHER SUBSTANCES

- ☐ Never used tobacco
- ☐ Current tobacco / nicotine
- ☐ Former tobacco / nicotine

Type, amount, and quit date if applicable

Alcohol use (type and amount)

Cannabis or other substance use relevant to anesthesia

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Medication and allergy list

Include prescriptions, over-the-counter medicines, vitamins, supplements, and injections.

Patient name | **Date of birth** | **Medical record no. (office use)**

ALLERGIES AND REACTIONS

Medication, food, latex, adhesive, or other allergy and the reaction

☐ No known medication allergies

CURRENT MEDICATIONS

Medication / supplement	Dose	How often	Last dose	Reason

MEDICINES THAT NEED SPECIFIC PRE-OP REVIEW

☐ Blood thinner / antiplatelet

☐ Insulin or diabetes medicine

☐ GLP-1 / weight-loss medicine

☐ Steroid

☐ Opioid or chronic pain medicine

☐ Herbal supplement

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Preoperative planning

Complete this page if a procedure is planned or being considered.

Patient name | **Date of birth** | **Medical record no. (office use)**

PLANNED CARE

Procedure or operation | **Planned date** | **Facility**

Surgeon / procedural clinician | **Office contact**

TESTING AND RECORDS

- ☐ Recent laboratory results
- ☐ ECG
- ☐ Cardiology records
- ☐ Pulmonary records
- ☐ Imaging
- ☐ Outside pre-op instructions

Where testing or records can be obtained

DAY-OF AND RECOVERY PLANNING

- ☐ Adult escort arranged
- ☐ Escort not yet arranged
- ☐ Help available at home

Escort / support person | **Phone** | **Transportation plan**

Questions or concerns about fasting, medication, anesthesia, pain, transportation, or recovery

DO NOT CHANGE PRESCRIBED MEDICATION ON YOUR OWN

Follow the written instructions given for your procedure. Call the appropriate clinical office if any instruction is unclear.

This form does not replace individualized medical or anesthesia instructions.

Notice of Privacy Practices acknowledgment

Signing confirms receipt or availability of the notice; it is not an authorization to disclose information.

Patient name | **Date of birth** | **Medical record no. (office use)**

I acknowledge that Virginia Surgical Services made its Notice of Privacy Practices available to me.

The notice explains how health information may be used and disclosed, my rights, and how to raise a privacy concern.

I understand that I may request a paper copy at any time and may review the current notice at va-ss.org/privacy-practices.

My signature does not authorize any use or disclosure beyond what applicable law permits.

Patient / personal representative signature | **Date**

Printed name | **Authority, if representative**

IF ACKNOWLEDGMENT WAS NOT OBTAINED (OFFICE USE)

☐ Patient declined to sign ☐ Patient unable to sign ☐ Emergency or other circumstance

Good-faith effort and reason acknowledgment was not obtained

Staff name / initials | **Date**

PRIVACY QUESTIONS OR COMPLAINTS

Privacy Officer, Virginia Surgical Services | 703-594-1583 | 3650 Joseph Siewick Drive, Suite 205B, Fairfax, Virginia 22033

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The practice will not retaliate against you for filing a complaint.