



PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Last Name: First Name: Middle Name:
Date of Birth: Soc Sec #: Sex: Marital Status:
Address: City/State: Zip Code:
E-mail:

HOME PHONE: CELL PHONE:
Employer Name: Phone:
Emergency Contact: Phone :

RESPONSIBLE PARTY INFORMATION

Last Name: First Name: Middle Name:
Home Phone #: Work #:
Address: City/State: Zip Code:

INSURANCE INFORMATION

Name of Primary Insurance Company:
Primary Care Physician: Phone #:
Subscriber Last Name: First Name: Middle Name:
Date of Birth: Soc Sec #: Sex: Relationship to Patient:
Policy #: Group #:
Employer Name: Phone #:
Address: City/State: Zip Code:

Secondary Insurance: YES (If yes, please complete additional insurance form) NO

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments deemed necessary. The administration of any needed anesthetics and the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient. The use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

MEDICARE PATIENTS: I authorize Primary Care Associates, P.C. to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Primary Care Associates, P.C..

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia, (whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Center of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the Virginia Health Department and appropriate counseling will be offered.

I have reviewed and understand my PATIENT RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature (or responsible party) Date:

I acknowledge that I have received a copy of Primary Care Associates' Notice of Privacy Practices, dated 3/1/03.

Signature of patient or Patient's Representative Date

Printed Name of Patient's Representative Relationship to Patient

Evidence of the authority of the patient's representative (please attach to this acknowledgement)

ADDITIONAL INSURANCE

Name of Secondary Insurance Company: _____

Primary Care Physician: _____ Phone #: _____

Subscriber Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Soc Sec #: _____ Sex: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Employer Name: _____ Phone #: _____

Address: _____ City/State: _____ Zip Code: _____

Name of Tertiary Insurance Company: _____

Primary Care Physician: _____ Phone #: _____

Subscriber Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Soc Sec #: _____ Sex: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Employer Name: _____ Phone #: _____

Address: _____ City/State: _____ Zip Code: _____

Patient Signature (or responsible party) _____ **Date** _____