

DEMOGRAPHICS

(703) 726-6393

LAST NAME		FIRST NAME		MIDDLE INITIAL	
SOCIAL SECURITY NUMBER		SEX		PREFIX/SUFFIX	
DATE OF BIRTH (mm/dd/yy)		STATUS (please circle one) Single Married Divorced Widowed Partner		STUDENT (please circle one) No Full Time Part Time	
STREET ADDRESS		CITY/STATE		ZIP CODE	
HOME PHONE (include area code)		WORK PHONE		CELL PHONE	
RACE (please circle one) White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native		ETHNICITY (please circle one) Hispanic or Latino Not Hispanic or Latino Unknown		PREFERRED LANGUAGE English Spanish Or other: _____	
EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER	
PREFERRED PHARMACY	PHARMACY PHONE NUMBER	EMAIL ADDRESS			

CONTACT/GUARANTOR INFORMATION

CONTACT (please circle at least one) Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME		FIRST NAME		MIDDLE INITIAL	
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIONSHIP TO PATIENT		SEX	MARITAL STATUS		
HOME ADDRESS		CITY/STATE		ZIP CODE	HOME PHONE		
EMPLOYER			WORK PHONE		JOB TITLE		

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT (please circle at least one) Guarantor Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME		FIRST NAME		MIDDLE INITIAL	
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIONSHIP TO PATIENT		SEX	MARITAL STATUS		
HOME ADDRESS		CITY/STATE		ZIP CODE	HOME PHONE		
EMPLOYER			WORK PHONE		JOB TITLE		

INSURANCE POLICY INFORMATION

POLICY NUMBER		GROUP ID		EFFECTIVE DATE	
TYPE (please circle one only) Health Auto Work. Comp. Other		PRIMARY INSURANCE? Yes No		END DATE	
NAME OF INSURANCE COMPANY/PLAN		INSURANCE COMPANY ADDRESS			PHONE NUMBER
INSURED'S NAME		DATE OF BIRTH (mm/dd/yy)		HOME PHONE	
INSURED'S MAILING ADDRESS			PRIMARY CARE PHYSICIAN (pcp) & or REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER		GROUP ID		EFFECTIVE DATE	
TYPE (please circle one only) Health Auto Work. Comp. Other		PRIMARY INSURANCE? Yes No		END DATE	
NAME OF INSURANCE COMPANY/PLAN		INSURANCE COMPANY ADDRESS			PHONE NUMBER
INSURED'S NAME		DATE OF BIRTH (mm/dd/yy)		HOME PHONE	

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Print Name

Date

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis

Date

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent