

## PATIENT INFORMATION FORM

### PATIENT INFORMATION

Please PRINT.

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M.I. \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M / F Birth Date: \_\_\_ / \_\_\_ / \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #s Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Employer: \_\_\_\_\_  
Status: married, single, widowed, divorced

**INSURANCE HOLDER** - The person who holds the insurance plan – often through employer.

Relationship (ex: self, spouse, father, mother): \_\_\_\_\_ If Self, skip this section.  
Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M.I. \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M / F Birth Date: \_\_\_ / \_\_\_ / \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #s Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Employer: \_\_\_\_\_

### PRIMARY INSURANCE

Insurance company: \_\_\_\_\_

Please bring all insurance cards with you to every office visit. Thank you.

### SECONDARY INSURANCE (if applicable)

Insurance company: \_\_\_\_\_

I authorize my insurance benefits to be paid directly to the physician. I acknowledge that I am financially responsible for all charges, and that it is my responsibility to verify that my insurance will cover any procedures that are performed at my request. If my insurance company requires a referral, I understand that it is my responsibility to obtain such a referral prior to my visit. If Medicare or my commercial insurance carrier should deny any charges, then I agree to be personally and fully responsible for any balance due for services rendered. 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 Loudoun Medical Group (LMG) or any of its affiliates, agents, or lenders. If I fail to meet my financial commitment and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

I authorize LMG to test my blood for hepatitis and HIV 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_