EVMS
MEDICAL GROUP

PATIENT REGISTRATION FORM

TODAY'S DATE:

DEPARTMENT:

(Please Print)

MRN:

PATIENT INFORMATION

PATIENT'S NAME: (LAST) (FIRST) MIDDLE	AGE:	SEX:	BIRTH DATE:	MARITAL STATUS (CIRCLE ONE) Single / Mar / Div / Sep / Wid ☐ ☐ ☐ ☐ ☐
SOCIAL SECURITY #.:	RACE:	ETHNICITY:		LANGUAGE:
STREET ADDRESS:	APT #:	CITY/ STATE:		ZIP CODE:
HOME PHONE #:	CELL PHONE #:	EMAIL:		COUNTRY:
EMPLOYER:	EMPLOYER ADDRESS:	EMP. CITY/ STATE:		EMP. ZIP CODE:
EMPLOYER PHONE #:	NEXT OF KIN:	NEXT OF KIN PHONE #:		RELATIONSHIP:
PRIMARY CARE PHYSICIAN:	PRIMARY CARE PHYSICIAN PHONE #:			
REFERRING PHYSICIAN:	REFERRING PHYSICIAN ADDRESS:	REF. CITY/STATE:		REF. ZIP CODE:

RESPONSIBLE PARTY INFORMATION

GUARANTOR NAME:	ADDRESS (IF DIFFERENT):	CITY/ STATE:	ZIP CODE:
PHONE #:	EMPLOYER:	EMP. PHONE #:	
EMPLOYER ADDRESS:	EMP. CITY/ STATE:	EMP. ZIP CODE:	
WAS AN INJURY INVOLVED? ☐ Yes ☐ No	IF YES > DATE OF INJURY:	TIME OF INJURY:	WAS IT WORK RELATED?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

NAME OF PRIMARY INSURANCE:	SUBSCRIBER'S NAME:		
RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?
SUBSCRIBER STREET ADDRESS:	APT #:	CITY/ STATE:	ZIP CODE:
ID #:	GROUP #:	PLAN #:	

(SECONDARY INSURANCE INFORMATION)

NAME OF SECONDARY INSURANCE (IF APPLICABLE):	SUBSCRIBER'S NAME:		
RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?
SUBSCRIBER STREET ADDRESS:	APT #:	CITY/ STATE:	ZIP CODE:
ID #:	GROUP #:	PLAN #:	

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: VIRGINIA LAW (VIRGINIA CODE SECTION 32.1-45.1) PROVIDES THAT WHEN EITHER A PERSON PROVIDING HEALTH CARE SERVICE OR A PATIENT IS DIRECTLY EXPOSED TO THE BODY FLUIDS OF THE OTHER IN A WAY THAT MAY TRANSMIT HUMAN IMMUNO-DEFICIENCY VIRUS (HIV) OR HEPATITIS B OR C VIRUS, SUCH OTHER PERSON IS DEEMED TO HAVE CONSENTED TO TESTING FOR THOSE VIRUSES AND TO RELEASE OF THE TEST RESULTS TO THE PERSON SO EXPOSED, AND ACTUAL CONSENT IS NOT REQUIRED.

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE ANY MEMBER OF EVMS MEDICAL GROUP AND/OR THEIR DESIGNEES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR VALID REFERRAL FORMS, REQUIRED BY THEIR MANAGED CARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR COURT COSTS, 25% ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY EVMS MEDICAL GROUP AND A $20 RETURN-CHECK-CHARGE, SHOULD THAT BECOME NECESSARY. IF MY INSURANCE CARRIER DOES NOT PAY MY CLAIM, I GIVE EVMS MEDICAL GROUP MY PERMISSION TO ALLOW THE VIRGINIA INSURANCE COMMISSIONER'S OFFICE TO BE CONTACTED ON MY BEHALF.

FOR HEALTH CARE OPERATIONS: WE MAY DISCLOSE YOUR MEDICAL INFORMATION IN ORDER TO OPERATE THE EVMS MEDICAL GROUP PRACTICE PLAN. FOR EXAMPLE, WE MAY USE YOUR MEDICAL INFORMATION IN ORDER TO EVALUATE THE QUALITY OF HEALTH CARE SERVICES, TO EVALUATE THE PERFORMANCE OF THE HEALTH CARE PROFESSIONALS, AND TEACHING AND TRAINING OF HEALTH CARE PERSONNEL. WE MAY ALSO PROVIDE YOUR MEDICAL INFORMATION TO OUR ACCOUNTANTS, ATTORNEY'S, CONSULTANTS, AND OTHERS IN ORDER TO MAKE SURE WE'RE COMPLYING WITH THE LAWS THAT AFFECT US.

PATIENT NAME (PRINT) PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE

WITNESS SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES: I HAVE RECEIVED OR HAVE BEEN OFFERED THE EVMS MEDICAL GROUP NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED BY EVMS MEDICAL GROUP AND ITS AFFILIATES.

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE