Virginia Health Center LLC

Date: # Patient Registration **Patient Number:**

Patient Information

First Name:_____ **Middle**:_____

Last Name:_____

Social Security No.:_____

Date of Birth:_____/_____/_____

Sex: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race:_____ **Ethnicity**:_____

How did you find us? ☐ Ad ☐ Family or Friend ☐ Website/Search Engine ☐ Angie's List ☐ Other

Home Address:_____

_____

City:_____**State**:_____**Zip**:_____

E-Mail: _____

Circle preferred number to call: Home Work Cell

Home Phone: (_____)_____

Work Phone: (_____)_____

Cell Phone: (_____)_____

Insurance Information (Please Provide Your Insurance Card to the Receptionist)

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Worker's Comp ☐ Other _____

Insurance Company: _____

Insured/Card Holder's Name:_____ Relationship:_____

Policy No.:_____ Group No.:_____ Phone: (_____)_____

Secondary Insurance Information (Please provide your insurance card to the receptionist)

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Worker's Comp ☐ Other _____

Insurance Company: _____

Insured/Card Holder's Name:_____ Relationship:_____

Policy No.:_____ Group No.:_____ Phone: (_____)_____

Workers' Compensation Information

Company Name:_____ Company Phone: (_____)_____

Supervisor's/Contact Name:_____ Phone: (_____)_____

Emergency Contact Information

Full Name:_____

Relationship:_____

Home Phone:_____ Work Phone:_____

Guarantor/Responsible Party

First Name:_____Middle:_____ Last Name:_____

Social Security No.:_____

Date of Birth:_____/_____/_____

Home Address:_____

City:_____State:_____Zip:_____

Home Phone: (_____)_____

Employer:_____

Address:_____

_____

City:_____State:_____Zip:_____

Daytime Phone: (_____)_____

Patient Financial Responsibility: Your insurance contract is between you, your employer and the insurance company. Please note that not all services are covered by all contracts. Non-payment of submitted claims by your insurance; non-covered services by your insurance or out of network charges are your responsibility. A fee of $30 will be charged for checks returned for insufficient funds. Balances older than 30 days may be subjected to additional collection fees. We encourage you to contact us promptly for assistance in the management of your account.

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to the Physician of the Medical and/or Surgical benefits, if any, otherwise payable to me for his/her services as described, realizing that I am ultimately responsible for all payments.

Additionally, I hereby authorize the Physician to release any information, acquired in the course of my treatment, necessary to process insurance claims.

_____ _____

Patient Signature (or Parent if Minor) **Date**