Ashburn Pediatrics

PATIENT INFORMATION SHEET

PARENT OR GUARDIAN: FINANCIALLY RESPONSIBLE		**TODAY'S DATE:**	
NAME:	SEX:	DATE OF BIRTH:	
SOCIAL SECURITY NUMBER:	RELATIONSHIP TO PATIENT:		
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:	
EMAIL ADDRESS:	EMPLOYER:	OCCUPATION:	
OTHER PARENT OR GUARDIAN: (only fill in that which is different from above)			
NAME:	SEX:	DATE OF BIRTH:	
SOCIAL SECURITY NUMBER:	RELATIONSHIP TO PATIENT:		
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:	
EMAIL ADDRESS:	EMPLOYER:	OCCUPATION:	
PREFERRED PHARMACY:			
PRIMARY INSURANCE COMPANY:	PHONE:		
GROUP#	NAME OF POLICY HOLDER:		
ADDRESS:	CITY:	STATE:	ZIP:

CONCERNING INSURANCE

I HEREBY AUTHORIZE THE PHYSICIAN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED.

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE CONVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURACE CARRIER. A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHROIZATION MAY BE REVOKED IN WRITING BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME.

SIGNATURE OF PARENT OR INSURED: _____ **DATE:** _____

ASSIGNEMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO THE PHYSICIAN FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE CARRIER.

SIGNATURE OF PARENT OR INSURED:_____ **DATE:**_____

PATIENT(S)

1. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

2. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

3. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

4. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

PATIENT(S)

5. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

6. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

7. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

8. Name:

DATE OF BIRTH: **SEX: M/F**

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

OTHER:_____

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 and employee should be directly exposed to your blood or body fluids in a way that many 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 or Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis Date Signed

_____ _____

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