

## Martha Jefferson Medical Group

Instructions: Please print and complete this form on both sides and bring it with you to your first appointment.

### Patient Information

Patient (Last, First, Middle)		SSN
Street Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
OK to leave message on <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> cell phone ? (check all that apply)		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Marital Status M S W D
Patient's Employer		
Street address		
City	State	Zip

### Who is responsible for paying the bill? (if different from above)

Name (Last, First, Middle)		SSN
Street Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth		
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/> Employer		
Employer Name		
Street Address		
City	State	Zip

### Insurance Information (Please provide a copy of your insurance card(s))

Who is the **subscriber** of the insurance? If it is the same as the patient, skip this section.

Name (Last, First, Middle)		SSN
Street Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other Date of Birth		

### Emergency Contact Information

Name:	Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Street Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone

### Minor Information—Who is authorized to bring a minor child (under age 18) in for treatment?

Name: \_\_\_\_\_

Who has legal custody of the minor? If different from above, please provide your custody agreement.

Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____		
Street Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone

# Martha Jefferson Medical Group

Patient Name:	Patient Date of Birth:
---------------	------------------------

**Release of Information—To whom can we release information about the patient?**

Name Relationship to patient
Name Relationship to Patient
Name Relationship to Patient

**Deemed Consent for Designated Blood Borne Pathogens  
Consent to Medical Care, and Release of Information and Notice**

Notice: This office participates in the Commonwealth of Virginia Prescription Monitoring Program for Controlled Substances and may access the computerized database to retrieve information on prescribed medications.

Virginia law requires health care providers to notify you that the Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility:

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Martha Jefferson Medical Group is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, Martha Jefferson Medical Group will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned, Martha Jefferson Medical Group policy protects you as a patient, should you be exposed.

I voluntarily consent to medical care at Martha Jefferson Medical Group which may include examinations, tests, photographs and treatments by doctors and staff. No promises have been made to me as to the results of treatments or examinations.

I certify that the information I have reported in regard to my insurance coverage is correct. I hereby authorize the release of pertinent information to my insurance company or CMS and any other doctors involved with my case. I authorize insurance benefits to be paid directly to this office, realizing that I am responsible to pay for any non-covered services. I understand that if my account becomes delinquent and is assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees.

I have read, understand, and agree to all terms specified in the Financial Policy. I acknowledge that I have received or been offered a copy of Martha Jefferson Medical Group's Notice of Privacy Practices.

Patient's relationship to signer:  Patient  Spouse  Parent  Child  Other \_\_\_\_\_  
 Patient is unable to sign or acknowledge

Sign	Date
Sign	Date
Sign	Date