

ASHBURN PEDIATRICS
PATIENT INFORMATION SHEET

DATE: _____ CHART NUMBER: _____

PREFERRED PHARMACY- _____

PARENT OR GUARDIAN: FINANCIALLY RESPONSIBLE

NAME: _____ HOME PHONE: ()-_____-_____

ADDRESS: _____ WORK PHONE: ()-_____-_____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: ()-_____-_____

EMAIL ADDRESS: _____ DATE OF BIRTH ____/____/____ SEX: M/F

SOCIAL SECURITY NUMBER: ____-____-____ REFERRED BY: _____

EMPLOYER: _____ OCCUPATION: _____

RELATIONSHIP TO PATIENT(S): _____

OTHER PARENT OR GUARDIAN: (only fill in that which is different from above)

NAME: _____ HOME PHONE: ()-_____-_____

ADDRESS: _____ WORK PHONE: ()-_____-_____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: ()-_____-_____

DATE OF BIRTH: ____/____/____ SEX: M/F SOCIAL SECURITY NO: ____-____-____

EMPLOYER: _____ OCCUPATION: _____

RELATIONSHIP TO PATIENT(S): _____

PATIENT(S):

NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M/F

NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M/F

NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M/F

NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M/F

NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M/F

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____ PHONE: ()-_____-_____

ADDRESS: _____ ID#: _____

CITY: _____ STATE: _____ ZIP: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT(S): _____

****Please Sign Back****

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 COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER. A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

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

SIGNATURE OF PARENT OR INSURED

DATE

ASSIGNMENT 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

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 or employee should be directly exposed to your blood or body fluids in a way that may 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 of Patient, Parent/Legal Guardian, or Person Acting In Loco Parentis

Date Signed

Relationship (if signature is not of Patient)

Signature of Person Obtaining Consent