IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

PATIENT INFORMATION

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL | SOCIAL SECURITY NO.

ADDRESS & MAILING ADDRESS | CITY | STATE | ZIP CODE | EMAIL

SEX ☐ M ☐ F | MARITAL STATUS ☐ S ☐ D ☐ M ☐ W | DATE OF BIRTH / / | AGE | **MEDICINES ALLERGIC TO** ➡

HOME PHONE ( ) | WORK PHONE ( ) | CELL PHONE ( ) | OCCUPATION | EMPLOYER

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

SPOUSE RESPONSIBLE PARTY

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH / / | SOCIAL SECURITY NO.

ADDRESS & MAILING ADDRESS | CITY | STATE | ZIP CODE | EMAIL

HOME PHONE ( ) | WORK PHONE ( ) | CELL PHONE ( )

RELATIONSHIP TO PATIENT | OCCUPATION | EMPLOYER

EMERGENCY

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH / / | SOCIAL SECURITY NO.

EMERGENCY CONTACT AT DIFFERENT ADDRESS | RELATIONSHIP | PHONE ( )

ADDRESS | CITY | STATE | ZIP CODE

PHARMACY

PHARMACY NAME | PHONE ( ) | FAX ( )

ADDRESS | CITY | STATE | ZIP CODE

INSURANCE

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.

INSURANCE CO. #1

COMPANY NAME

ID NO. | GROUP NO.

SUBSCRIBER'S NAME | DATE OF BIRTH / /

RELATION TO PATIENT

INSURANCE CO. #2

COMPANY NAME

ID NO. | GROUP NO.

SUBSCRIBER'S NAME | DATE OF BIRTH / /

RELATION TO PATIENT

I WAS REFERRED TO THIS PRACTICE BY:

DEEMED CONSENT

Under Virginia law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or hepatitis B or C viruses, you shall be deemed to have consented to testing for infection with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

HIPAA Acknowledgement: All patients must initial one of the following:

_____ **I hereby acknowledge that I have been provided with a copy of the Peninsula Women's Care Notice of Privacy Policies.**

_____ **I hereby acknowledge that I have been provided with a copy of the Peninsula Women's Care Notice of Privacy Policies but decline to accept it at this time.**

SIGNATURE OF PATIENT / RESPONSIBLE PARTY | RELATIONSHIP TO PATIENT | DATE

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by any Peninsula Women's Care provider and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines does not constitute covered services as well as attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY | RELATIONSHIP TO PATIENT | DATE

AUTHORIZATION FOR RELEASE OF MEDICAL AND FINANCIAL INFORMATION

I, _____ (patient's name) hereby authorize Peninsula Women's Care to release or discuss any of my medical/financial information with the following individuals listed below:

NAME	RELATIONSHIP TO PATIENT	NAME	RELATIONSHIP TO PATIENT