LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Family Allergy Center

DEMOGRAPHICS

LAST NAME		FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER		SEX		PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*		STATUS *(please circle one)* Single Married Divorced Widowed Partner		STUDENT *(please circle one)* No Full Time Part Time
STREET ADDRESS		CITY/STATE		ZIP CODE
HOME PHONE *(include area code)*		WORK PHONE		CELL PHONE
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 Or other: ________________________
EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER
PREFERRED PHARMACY	PHARMACY PHONE NUMBER		EMAIL ADDRESS	

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle at least one)* Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME	FIRST NAME		MIDDLE INITIAL
SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS	
HOME ADDRESS		CITY/STATE	ZIP CODE	HOME PHONE	
EMPLOYER		WORK PHONE		JOB TITLE	

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please circle at least one)* **Guarantor** Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS		CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER		WORK PHONE		JOB TITLE

Over →

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $________ Specialist: $_________
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSCIAN (pcp) & or REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $________ Specialist: $_________
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

_______________________________________ _______________

Print Name **Date**

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Signature

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

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Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date**

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