

DEMOGRAPHICS

			FIRST NAME			MIDDLE INITI.		
SOCIAL SECURITY NUMBER	ER		SEX			PREFIX/SUFFI	X	
DATE OF BIRTH (mm/dd/yy)			STATUS (please circle one)			STUDENT (plea	ase circle one)	
Ditto of Bictit (mindady))			Single Married Divorced Widowed			No No	Full Time	Part Time
CTREET ADDRESS			Partne CITY/STATE		lowed	ZIP CODE	Tun Tinic	Tart Time
STREET ADDRESS			CITY/STATE			ZIP CODE		
HOME PHONE (include area code)			WORK PHONE			CELL PHONE		
RACE (please circle one)			ETHNICITY (please circle one)			PREFERRED LANGUAGE		
White Black/African American Asian			Hispanic or Latino	Not Hispanic	or Latino	English Spanish		
Hawaiian/Other Pacific Islander Other Race American Indian/Ala Native						Or other:		
EMPLOYER	JOB TITLE/ST	ATUS	EMPLOYER ADDRESS			EMPLOYER PHONE NUMBER		
PREFERRED PHARMACY	PHARMACY	PHONE NUMBE	ER	EMAIL AI	DDRESS			
Emergency Contact Next of Kin Insured Authorized to Seek Treatment					FIRST N	AME MARITAL	STATUS	MIDDLE INITIAI
351 (Social Security number)	Diffe of Bittii (mingate),)) KEE/III	onom romment		OL21	W. HCITAL	3311103	
	ME ADDRESS					DE HOME PHONE		
HOME ADDRESS		CITY/S1	ГАТЕ		ZIP COD	DE HOME PH	ONE	
HOME ADDRESS EMPLOYER			FATE WORK PHONE			HOME PH	ONE	
EMPLOYER	uarantor informatio			e assume	JOE	3 TITLE		nrty.
EMPLOYER If the Go CONTACT (please circle at le G Emergency Cont	ast one) uarantor	on is left bla	WORK PHONE		JOE	3 TITLE	ble/billed pa	nrty.
EMPLOYER If the Gu CONTACT (please circle at le G Emergency Cont	ast one) uarantor act Next of Kin	on is left bla	work phone ank, the patient will b		JOE	3 TITLE the responsi	ble/billed pa	nrty.
EMPLOYER If the Go CONTACT (please circle at le G Emergency Cont Insured A	ast one) uarantor act Next of Kin uthorized to Seek Treatment DATE OF BIRTH	on is left bla	work PHONE nnk, the patient will b ST NAME	FIRST	JOE d to be	the responsil	ble/billed pa	arty.

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECT	IVE DATE
TYPE (please circle one only) Health Auto Work. Comp.	PRIMARY INSURANCE?	END DATE	COPAY	MENT AMOUNT
Other	Yes No		Office:	\$ Specialist: \$
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY	ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH (mm/dd/	yy)	HOME PHONE	3
		•		
INSURED'S MAILING ADDRESS	Pl	RIMARY CARE PHYSCIAN	(pcp) & or REFERRI	NG PHYSICIAN
SECONDAR	RY INSURANCE INFO	ORMATION (if app	plicable)	
POLICY NUMBER	GROUP ID		EFFECT	IVE DATE
TYPE (please circle one only)	PRIMARY INSURANCE?	END DATE	COPAY	MENT AMOUNT
Health Auto Work. Comp.	Yes No			\$ Specialist: \$
Other				
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY	ADDRESS		PHONE NUMBER
The state of the s			*****	
I authorize my insurance benefits to be paid consent to the release and re-disclosure of my my account for any amounts due from me or	medical record to en	n and I am financia	collection, ver	for all charges. I hereby ification or settlement of
I authorize my insurance benefits to be paid o	directly to the physiciand medical record to enaughter any third party payor C, or any of its affiliate orize LMG to test my be	n and I am financianble or facilitate the health maintenances or agents, lenders lood for hepatitis a	ally responsible e collection, ver ce organization s, or any third p nd/or the AIDS	for all charges. I hereby ification or settlement of , insurer or other health party servicer acting for s virus, if in their opinion;
I authorize my insurance benefits to be paid of consent to the release and re-disclosure of my my account for any amounts due from me or benefit plan. This consent applies to LMG, PC LMG, PC or any of its affiliates. I also author an employee has suffered an exposure incident	directly to the physiciand medical record to enaughter any third party payor C, or any of its affiliate orize LMG to test my be	n and I am financianble or facilitate the health maintenances or agents, lenders lood for hepatitis a	ally responsible e collection, ver ce organization s, or any third p nd/or the AIDS	for all charges. I hereby ification or settlement of , insurer or other health party servicer acting for s virus, if in their opinion;
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I authorize my insurance benefits to be paid consent to the release and re-disclosure of my my account for any amounts due from me or benefit plan. This consent applies to LMG, Pc LMG, PC or any of its affiliates. I also autho an employee has suffered an exposure incider Administration. Print Name Signature NOTICE OF DEEMIT LMG is required by § 32.1-45.1 of the Code of 1. If any LMG health care professional, work may transmit disease, your blood will be to for Hepatitis B and C. A physician or oth 45.1(A), you are deemed to have consented 2. If you should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease, that person's blood we should be directly exposed to blood may transmit disease.	directly to the physicial of medical record to enary third party payor C, or any of its affiliate orize LMG to test my but as a result of my tree. ED CONSENT FOR HE Virginia (1950), as ameter or employee should ested for infection with the health care provided to the release of the test or body fluids of a LM will be tested for infection other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the content of the release of the test or other health care proved the release of the test or other health care proved the release of the test or other health care proved the release of the test or other health care proved the release of the test or other health care proved the release of the test or other health care proved the release of the test or other health care proved the release of the test or other health care proved the release of the test of the release of the release of the test of the release of the release of the test of the release of the test of the release of the test of the release of the release of the test of the release of the test of the release of the test of the release of the release of the test of the release of the test of the release of	n and I am financia able or facilitate the health maintenances or agents, lenders lood for hepatitis a atment, as defined latter, as defined latte	Date OR C TESTING To your blood of the cesult of the test of the	for all charges. I hereby ification or settlement of insurer or other health party servicer acting for a virus, if in their opinion; ional Safety and Health are body fluids in a way that a "AIDS" virus), as well as Under Va. Code § 32.1- or employee in a way that irus (the "AIDS" virus), as result of the test.

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