



PATIENT INFORMATION

Please Print

Last Name:
First, M.I.:
Address:
City: State: Zip:
Home Phone:
Date of Birth: Sex: M / F
Marital Status: Spouse's Name:
E-Mail Address:

Social Security #:
E-Mail Address:
Employer:
Address:
City: State: Zip:
Work Phone:
Cell Phone:
Primary VMA Dr.:

Responsible Party (If patient is a minor or employer is responsible)

Last Name:
First Name:
Relation:

Emergency Contact:

Name:
Phone:
Relation:

INSURANCE INFORMATION

PRIMARY POLICY HOLDER

SECONDARY POLICY HOLDER

Company Name:
Company Address:
ID / Certificate #:
Group #:
Plan #:
Policy Holder:

Company Name:
Company Address:
ID / Certificate #:
Group #:
Plan #:
Policy Holder:

I, the undersigned, hereby acknowledge that it is the policy of this office that payment due made at each visit and I am responsible for payment of all services rendered on my behalf. In the event that failure to pay results in referral of my account for collection, I agree to pay collection or attorney fees. If the treating physician is a participant in a HMO, PPO or IPA of which I am a member, I agree to pay any co-payment required by my particular plan. Exception to this policy must be confirmed in advance of service.

Patient's Signature: Date:

MEDICARE PATIENTS ONLY:

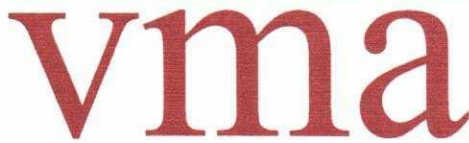
I request that payment of authorized Medicare Benefits be made either to me or on my behalf to M.D. for any services rendered to me. I authorized any holder of medical information about me to give the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: Date:

OTHER INSURANCE PATIENTS:

I authorize payment of medical benefits to the physician or supplier of services rendered.

I authorized release of my medical information necessary to process this claim and also certify that the information obtained herein is correct.



PATIENT MEDICAL HISTORY

Name: D.O.B.: Age: Sex:
Married: Single: Divorced: Separated: Widow:
Ethnic Origin: Occupation:

Social History

Smoke: () Yes () No If Yes: Packs Per Day: Years Smoked:
Alcohol Use: Exercise: (Hrs/Wk) Sleep: (Hrs/Day)

Females

Last Menstrual Period: Menopausal Symptoms:
of Pregnancies: # of Children:
Last Pap Smear: Last Mammogram:
Have you ever had a Hysterectomy: If yes, were your Ovaries removed:

Medications:
Drug Allergies:
Past medical Problems:
Past Operations:
Serious Injuries:
Diagnostic Studies: (X-rays, exercise, stress test, sigmoidoscope, etc.)

Family Medical History: (Hypertension, Diabetes, Stroke, Heart disease, Lung disease, Liver disease, Kidney disease, TB, Cancer (what kind?))

Mother: Father:
Grandmother: Grandfather:
Siblings: Children:
Aunts: Uncles:

Immunizations:

Last Tetanus: Last PPD:



AUTHORIZED REPRESENTATIVE FORM

With my consent, Virginia Medical Alliance may call my home or other designated location and leave a message on voice mail or speak to the authorized representative listed below who can receive information pertaining to my clinical care, including test results, instructions on course of treatment and appointment reminders. With my consent, Virginia Medical Alliance may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations.

1. Name: _____

Relation to patient: _____

2. Name: _____

Relation to patient: _____

Please check the appropriate box if you will allow Virginia Medical Alliance to leave health information on your home phone or other designated voice mail system.

Yes _____ No _____

Please print home, work and cell phone numbers below:

Home #: _____

Work #: _____

Cell #: _____

Patient's Name (Print): _____

Patient's Signature: _____

Date: _____



**CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS**

I consent to the use or disclosure of my protected health information by my physician at Virginia Medical Alliance, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care or to conduct health operations of Virginia Medical Alliance, P.C.

I have the right to revoke this consent in writing at any time, except for the extent that my physician or Virginia Medical Alliance, P.C. has taken action in reliance on this consent.

My “protected health information” (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative/s Authority