

**Patient Registration
Fox Mill Family Practice**

• **Responsible Party Information / Guarantor**

Guarantor Name: (last) _____ (first) _____ (initial) _____ Date of birth: ___/___/___
Relationship to patient: ___ Self ___ Spouse ___ Other _____ Social Security Number: _____
Home Address: _____ City _____ State ___ Zip ___
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
Employer Name & Address: _____

• **Patient - Personal Information**

Patient's Name: (last) _____ (first) _____ (initial) _____
Home Address: _____ City _____ State ___ Zip ___
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: ___/___/___ Sex: ___ Male ___ Female Social Security Number: _____
Marital Status: _____ Race: _____ Ethnicity: _____ Language: _____
Email Address: _____
Employer's Name & Address: _____
Spouse's Name: _____ Spouse's Work Number: _____
** Preferred Pharmacy: _____ Fax Number: _____

• **Primary Insurance Carrier Information**

Insurance Company Name: _____ Policy Effective Date: _____
Insurance Address: _____
Policy Holder's Name: _____ Date of Birth: ___/___/___
Relation to patient: _____ Policy Holder's Social Security Number: _____
Insurance Policy Number: _____ Insurance Group Number: _____
Employer's Name & Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

• **Secondary Insurance Carrier Information**

Insurance Company Name: _____ Policy Effective Date: _____
Insurance Address: _____
Policy Holder's Name: _____ Date of Birth: ___/___/___
Relation to patient: _____ Policy Holder's Social Security Number: _____
Insurance Policy Number: _____ Insurance Group Number: _____
Employer's Name & Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

I hereby authorize Fox Mill Family Practice to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Fox Mill Family Practice of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by my carrier. A photocopy of this authorization shall be considered as valid as the original.

Patient's Signature (or responsible party)

Date

In accordance with the provisions of Section 32.1 - 45.1 of the Code of Virginia, (whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Virginia Health Department. Appropriate counseling will be offered. I certify that I have read and understand the above statement and consent fully and voluntarily to its contents.

Patient or Parent/Legal Guardian Signature

Date

Medical Record #: _____

Processed By: _____