RAPPAHANNOCK FAMILY PHYSICIANS

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City, State, Zip Code: _____Work Phone: _____

Gender: _____ Marital Status: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Preferred Method of Contact (Check one): ___Home ___Cell ___Work ___Email

Race (Check One): ___African American/Black ___ American Indian/Alaskan Native ___ Asian ___Caucasian/White

___Native Hawaiian/Pacific Islander ___Other ___Unknown ___ Declined

Ethnicity (Check One): ___ Hispanic/Latino ___Not Hispanic/Latino ___Unknown ___Declined

Preferred Pharmacy Name and Zip Code: _____

MEDICAL INSURANCE INFORMATION

Primary Carrier: _____ Policy/Member Number: _____

Policy Holder/Subscriber Name: _____ Policy Holder's DOB: _____

Secondary Carrier: _____ Policy/Member Number: _____

Policy Holder/Subscriber Name: _____ Policy Holder's DOB: _____

GUARANTOR/LEGAL GUARDIAN INFORMATION (Only if Patient is a Minor)

Full Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City, State, Zip Code: _____Work Phone: _____

Gender: _____ Marital Status: _____ Cell Phone: _____

Email Address: _____ Employer: _____

OTHER INFORMATION

Emergency Contact: _____ Relationship to Patient: _____

Contact Phone Number: Cell: _____ Work Phone: _____

How were you referred to our practice? _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld due to insurance coverage or pending claims. I acknowledge that all proceeds of insurance are assigned to Rappahannock Family Physicians where applicable and that Rappahannock Family Physicians assumes no responsibility for the collection of any proceeds of insurance.

If my account becomes assigned to a collection agency, I agree to pay all costs of collection, including agency fees, court costs, and reasonable attorney fees.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____