EASTERN VIRGINIA MEDICAL SCHOOL
HEALTH SERVICES
PATIENT INFORMATION

DR.	GROUP #	MEDICAL RECORDS NO.	CHART #
YOUR E-MAIL:			

❑ NEW ❑ ESTAB.	DATE	PRIMARY CARE PHYSICIAN	PCP TELEPHONE NO. ( )

PATIENT INFORMATION

NAME (LAST) (FIRST) (MIDDLE)	AGE	BIRTH DATE MO. DAY YEAR	SOCIAL SECURITY NUMBER	SEX
STREET ADDRESS, APT #,	CITY, STATE, ZIP		HOME TELEPHONE NO.	
OCCUPATION (INDICATE IF STUDENT)	EMPLOYED BY	WORK TELEPHONE NO.	CELL TELEPHONE NO.	
HOW WERE YOU REFERRED TO EVMS HEALTH SERVICES? (PHYSICIAN, ER, PHONE BOOK, ETC.)			MARITAL STATUS ❑ SINGLE ❑ MARRIED	
NAME OF NEXT OF KIN (not living with you)	RELATIONSHIP		TELEPHONE NO.	

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME *(AND/OR SPOUSE)* (LAST) (FIRST) (MIDDLE)	DATE OF BIRTH MO. DAY YEAR		SOCIAL SECURITY NUMBER	SEX
STREET ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE NO.
OCCUPATION	EMPLOYER			
EMPLOYER'S ADDRESS				WORK TELEPHONE NO.
WAS AN ACCIDENT INVOLVED? ❑ YES ❑ NO IF YES	DATE OF INJURY	TIME OF INJURY	WAS IT WORK RELATED?	

PAYMENT/INSURANCE INFORMATION

PLEASE CHECK IF APPLICABLE ❑ **NO INSURANCE**	PLEASE CHECK: **HOW WILL YOU BE PAYING?** ❑ CASH ❑ CHECK ❑ MC ❑ VISA

PRIMARY INSURANCE CARRIER NAME:		SUBSCRIBER NAME:	
ID #:		PLAN #:	
RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL/AUTHORIZATION # REQUIRED?:

SECONDARY INSURANCE CARRIER NAME:		SUBSCRIBER NAME:	
ID #:		PLAN #:	
RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?:

OTHER INSURANCE INFORMATION:

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANY MEMBER OF THE EASTERN VIRGINIA MEDICAL SCHOOL HEALTH SERVICES (EVMS HEALTH SERVICES) OF THE MEDICAL COLLEGE OF HAMPTON ROADS AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGN AGREES TO BE RESPONSIBLE FOR VALID REFERRAL FORMS, REQUIRED BY THEIR MANAGED CARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGN AGREES TO BE RESPONSIBLE FOR COURT COSTS, 25% ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY EVMS HEALTH SERVICES AND A $20 RETURN-CHECK CHARGE, SHOULD THAT BECOME NECESSARY. IF MY INSURANCE CARRIER DOES NOT PAY MY CLAIM, I GIVE EVMS HEALTH SERVICES MY PERMISSION TO ALLOW VIRGINIA INSURANCE COMMISSIONER'S OFFICE TO BE CONTACTED ON MY BEHALF.

_____________ (INITIALS) I HAVE RECEIVED (HAVE BEEN OFFERED) THE EVMS PRIVACY NOTICE WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED BY EVMS AND ITS AFFILIATES.

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PATIENT'S OR RESPONSIBILITY PARTY'S SIGNATURE

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EVMS HEALTH SERVICES WITNESS SIGNATURE

FORM #007L (REV 04/04)