

Patient Registration

Patient Information

Patient's Name _____

Mailing Address _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Patient's Employer _____

Birthdate _____ Marital Status _____

Male/Female _____ SS#: _____

Primary Care Physician _____

Primary Care Physician Phone _____

Emergency Contact Name _____

Emergency Contact Phone _____

Authorization to release information and pay benefits to physicians (lifetime form)

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to James M. Leipzig, M.D. for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or their insurance companies and its agents any information needed to determine these benefits payable for related services.

(Signature) (Date)

I authorize the release of complete medical information to my referring physician.

(Signature) (Date)

I authorize the release of complete medical information to any physician or other health care provider to whom I am referred by my physician.

(Signature) (Date)

In accordance with the provisions of Section 32.0-45.0 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 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, and person exposed, and the Virginia Health Department, appropriate counseling will be offered.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

(Patient or Parent/Legal Guardian Signature) (Date)