

Personal Information*

Patient*: _____ Suffix: Jr./Sr./Other: _____

Previous Name: _____ Preferred Name: _____

Mailing Address*: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Method of Contact for Appointment Reminders: Text Message Home Phone Cell Phone

Primary Care Doctor (PCP): _____ City: _____ Phone #: _____

Referring Provider: _____ City: _____ Phone #: _____

Date of Birth*: _____ Sex*: _____ Marital Status*: Single Married Widowed Separated Divorced

Social Security #: _____ - _____ - _____ Email: _____

Employment Status: Full Time Part Time Not Employed Self Employed Retired Active Military Unknown

Race*: Caucasian/White African American Asian Hawaiian/Pacific Islander Other: _____

Ethnicity*: Hispanic or Latino Non-Hispanic or Latino Other: _____

Language*: English Spanish Other: _____

Pharmacy Name: _____ City: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Would you like to use our email-enabled patient portal? YES or NO

Primary Insurance Information*

Insurance Name: _____ Member ID #: _____ Group #: _____

Insured's Information - (if not self)*

Name: _____ Date of Birth: _____ Sex: _____ Social Security #: _____ - _____ - _____

Relationship to Insured: _____ Marital Status*: Single Married Widowed Separated Divorced

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Secondary Insurance Information

Insurance Name: _____ Member ID #: _____ Group #: _____

Secondary Insured's Information - (if not self)

Name: _____ Date of Birth: _____ Sex: _____ Social Security #: _____ - _____ - _____

Relationship to Insured: _____ Marital Status*: Single Married Widowed Separated Divorced

Address: _____

Home #: _____ Work #: _____ Cell #: _____

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. **X _____ (Please initial)**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X _____ (Please initial)**

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. **X _____ (Please initial)**

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through Dr. First. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on
- all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. **X _____ (Please initial)**

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

Date

Relationship (if any)