CHICKAHOMINY FAMILY PRACTICE, INC.

New Market
2660 New Market Road
Richmond, VA 23231
804-795-1144
804-795-1052

New Kent
1850 Pocahontas Trail
Quinton, VA 23141
804-932-4388
804-932-9860

Providence Forge
9010 Pocahontas Trail
Providence Forge, VA 23140
804-932-4388
804-966-9712

Patient Information

Name: _____ Social Security #:_____
Last Name First Name Middle Initial

Birth Date: _____ Marital Status: _____ Sex**:** □ Male □ Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home phone No: ( )_____ Cell Phone No: ( )_____ Work Phone No: ( )_____

Email Address: _____

Emergency Contact: _____ Relationship:_____

Ph. No.:( )_____ Work No.:( )_____ ext. _____ Cell No.:( )_____

Preferred Language: **□ English □ Spanish □ Other**

Race: **□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ Caucasian/White □ Multiracial □ Refused/Declined**

Ethnicity: **□ Hispanic or Latino □ Not Hispanic or Latino □ Refused/Declined**

Insurance Information

Name of Insured: _____ Relationship to patient:_____

Date of Birth of Insured:_____ Social Security Number of Insured: _____

Name of Insurance Co.: _____ Group No.:_____ ID No.:_____

Responsible Party (Person Responsible for any unpaid balance)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip:_____

Relationship: _____ Social Security No.: _____

Employer: _____ Work No.: _____ Ext. _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO CHICKAHOMINY FAMILY PRACTICE, INC.

I hereby authorize the physicians designated to release information acquired in the course of my examination. This information will be used to help obtain insurance reimbursement or assist other physicians regarding my care. I hereby assign payment directly to the designated physicians for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I understand that any overpayment made by my insurance company will be credited to my account.

I certify that the information I have given is correct and true to the best of my knowledge. "The undersigned jointly and severally guarantees payment to *Chickahominy Family Practice, Inc.,* the payment of all charges incurred by the patient, including reasonable collection agency or attorney's fees, if applicable."

Signature of Patient or parent/guardian if a minor: _____ Date: _____