PATIENT REGISTRATION FORM

COLONIAL MEDCARE, P.C.

Referring Physician: _____ Referring Physician Telephone: _____

PATIENT INFORMATION

Name (last) _____ (First) _____(M.I.)_____
Address _____City_____
State _____ Zip _____ (M/F) ___ SS# _____
Birth date _____ Age _____ Home Phone _____Work Phone# _____
Marital Status _____Employer: _____
Employer Address: _____

EMERGENCY CONTACT _____ Phone# _____

RESPONSIBLE PARTY

Guarantor's Name _____
Address _____
Pt Relation to Guarantor _____ Guarantor's Employer _____
Guarantor SS# _____Guarantor Birth date _____ (M/F) _____

PRIMARY INSURANCE: BOTH AREAS NEED TO BE COMPLETED, EVEN IF YOU HAVE YOUR CARDS

Name of Insurance Company _____ Policy Holder _____
Pt Relation to Policyholder _____ ID# _____ Group # _____
Ins Address _____
Ins. Phone # _____ Policyholder Birth date _____ (M/F) _____

SECONDARY INSURANCE

Name of Insurance Company _____ Policy Holder _____
Pt Relation to Policyholder _____ ID# _____Group # _____
Ins Address _____
Ins. Phone # _____ Policyholder Birth date _____ (M/F) _____

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medications; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees may consider medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I hereby authorize Colonial Medcare, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Colonial Medcare, P.C. of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original. Further, I acknowledge that I am indebted for past due charges and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay all collection and court cost including attorney fees.

MEDICARE PATIENTS: I authorize Colonial Medcare, P.C., to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Colonial Medcare, P.C.

In accordance with the provisions of Section 32.1-45.1 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 a 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 for testing for infection with human immunodeficiency virus and Hepatitis A, B and C. If there is an exposure and the patient's test is positive the attending physicians will notify the patient, any person exposed, and the Virginia Health Department and appropriate counseling will be offered. I have reviewed and understand my PATIENT RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guarantor Signature _____ **Date**: _____