1020 Bill Tuck Hwy #900, South Boston, VA 24592
Phone: 434-572-8921 Fax: 434-575-1290

PATIENT DEMOGRAPHIC FORM

First Name _____M.I. ___Last Name _____ Date of Birth __/ _____/

SSN __- _____- _____ Driver's License _____

Sex: F / M Language _____ Race: _____ Ethnicity: □ Hispanic / □ not Hispanic

Marital Status: Single / Married / Divorced / Separated / Widowed

Employment Status: Employed / Retired / Student Name of Employer _____

Preferred Communication: □ Phone / □ Mail / □ Email

Send Reminder: □ By Phone (Voice) □ By Phone (Text message) □ By Email

Address _____

City _____State ___Zip _____ Home Phone _____Mobile

_____Work ___Other _____ Email _

RESPONSIBLE PARTY

□ Self □ Other (please fill in the information below)

First name M.I. Last Name

Relationship to patient

Address: City State Zip

Home Phone Mobile Work

Email

EMERGENCY CONTACT

Name Relationship to Patient

Address City State Zip

Home Phone Mobile Work

Email _____

INSURANCE INFORMATION

If you have no insurance, please check here □

(We will make a copy of your Insurance Card. However, we do request that you fill in the information below)

Insurance _____ID# _____GROUP# _____POLICY HOLDER _____

RELEASE OF MEDICAL INFORMATION

I authorize *Fuller-Roberts OB/GYN & Primary Care,* to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to *Fuller-Roberts OB/GYN & Primary Care.* I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and Mastercard. All medical services provided are directly charged to the patient or responsible party. If our physician is contacted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge $15.00 for a “no show” appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician’s office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

NOTICE OF PRIVACY PRACTICES

I hereby state that I have received and reviewed the Health Insurance Portability and Accountability Act (HIPPA)

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE INFORMATION AND POLICIES

Signature _____Date _____