SENTARA®

Physician Practices

Patient Registration Form

Last Name_____ First Name_____ MI____

AKA (Also Known As) /Previous Last Name(s)_____

Social Security #_____-_____-_____ Date of Birth_____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ___Married ___Single ___Divorced ___Legally Separated ___Widowed ____ Life Partner

Home Address _____

_____

City_____ State_____ Zip Code_____

Home Phone(_____)_____ Cell Phone(_____)_____

Alternate Phone(_____)_____ Alternate Phone Info _____

E-Mail_____

Patient/Family Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Alt Phone ☐ E-Mail ☐ Text

Primary Care Physician/Pediatrician_____

If pediatric patient, please list siblings _____

_____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Pacific Islander or Native Hawaiian ☐ Other Race – Please Print_____

Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

☐ Other/Unknown – Please Print if Other_____

Language Preference: If other than English- Please Print_____

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication?

If yes, Please check appropriate item(s): ☐ Vision ☐ Hearing

Patient's Employer_____

Address_____

City_____ State_____ Zip Code_____

Work Phone Number(_____)_____ Ext_____

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients ☐ Guarantor? ☐ Legal Guardian?

Guarantor/Legal Guardian Name_____ Social Security #_____-_____-_____

Patient's Relationship to Guarantor/Legal Guardian: ☐ Spouse ☐ Dependent Child ☐ Student

Date of Birth _____/_____/_____ ☐ Other – Please Print_____

Guarantor/Legal Guardian Home Address_____

_____

City_____State _____Zip Code_____

Home Phone (_____)_____ Cell Phone(_____)_____Work Phone(_____)_____

Guarantor/Legal Guardian Employer Name & Address_____

_____

City_____ State_____ Zip Code_____

Emergency Contact - Who to call in the event of an Emergency

1. Name_____ Relationship_____

   Cell/Hm Phone #(_____)_____ Work Phone #(_____)_____

2. Name_____ Relationship_____

   Cell/ Hm Phone #(_____)_____ Work Phone #(_____)_____

Is your visit due to a job related injury or automobile accident? ☐ Yes ☐ No

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) ☐ Yes ☐ No

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Does the patient have insurance? ☐ Yes ☐ No

Primary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Primary Insurance***

Plan Name_____

Policy Holder's Name_____ Gender: ☐ Male ☐ Female

Policy Holder's #_____-_____-_____ Policy Holder's Date of Birth _____/_____/_____

Secondary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Secondary Insurance***

Plan Name_____

Policy Holder's Name_____ Gender: ☐ Male ☐ Female

Policy Holder's #_____-_____-_____ Policy Holder's Date of Birth _____/_____/_____

Patient/Guarantor Printed Name_____

Patient/Guarantor Signature_____ **Date**_____/_____/_____

HEALTH ASSESSMENT

Please take a brief moment to complete this form to the best of your ability. The Health Assessment serves as an important component of your complete medical record. Any information you give is voluntary and will be kept strictly confidential. Thank you.

Name _____ **Date** _____

Age _____ **Sex** _____ **Medical doctor** _____

Height _____ **ft** _____ **in** **Weight** _____ **lbs**

Medical Conditions:

Heart Disease	Y	N	Lung Disease	Y	N
High Blood Pressure	Y	N	Kidney Disease	Y	N
Diabetes	Y	N	Vascular Disease	Y	N
High Cholesterol	Y	N	Other (List) _____		

Drug Allergies _____

Medications (Drug and dosing schedule)

Prior Surgical Procedures: _____

Health Survey- Do you currently have or have you recently had any of the conditions listed below? Please circle yes or no.

General			**Cardiovascular**		
Weight loss	Yes	No	Chest pain	Yes	No
Loss of appetite	Yes	No	Irregular heart beat	Yes	No
Eyes			Palpitations	Yes	No
Glasses	Yes	No	Heart attack	Yes	No
Blurred vision	Yes	No	Pacemaker	Yes	No
Blindness	Yes	No	**Gastrointestinal**		
Double vision	Yes	No	Nausea/vomiting	Yes	No
Ears			Diarrhea	Yes	No
Pain	Yes	No	Blood in stool	Yes	No
Infections	Yes	No	Constipation	Yes	No
Hearing loss	Yes	No	**Extremities**		
Vertigo	Yes	No	Pain when walking	Yes	No
Neck			Pain at rest	Yes	No
Hoarseness	Yes	No	Pain at night	Yes	No
Difficulty swallowing	Yes	No	Cramps	Yes	No
Lumps	Yes	No	Ulcers/wounds	Yes	No
Thyroid problems	Yes	No	Blood clots	Yes	No
Neck radiation	Yes	No	Varicose veins	Yes	No
Chest			**Neurologic**		
Shortness of breath	Yes	No	Unstable Walking	Yes	No
Chronic cough	Yes	No	Numbness in arms/legs	Yes	No
Wheezing	Yes	No	Weakness in arms/legs	Yes	No
Sputum production	Yes	No	**Blood**		
Infections			Bleeding problems	Yes	No
Tuberculosis	Yes	No	Clotting disorder	Yes	No
Hepatitis	Yes	No	**Psychiatric**	Yes	No

Sentara Martha Jefferson Medical Group
590 Peter Jefferson Parkway, P.O. Box 1583
Charlottesville, VA 22911
Phone (800)-295-0526 Fax (434) 654-7752

Sharing Information with Family and Friends

Sentara Martha Jefferson Medical Group has a Notice of Privacy Practices which describes how we may use and disclose, and how you may access, your protected health information. At times spouses, children or others may call on your behalf. If you would like us to share your protected health information with others, please indicate to whom we may disclose this information. If you do not let us know who we may speak to, we will **NOT** discuss your protected health information with them.

I,_____ , date of birth _____, give my permission to Sentara Martha Jefferson Medical Group to discuss my medical care and/or to leave messages with the following people:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

Patient Signature: _____ Date: ___/___/_____ (initial date)

I have reviewed the above and no changes are necessary:

Patient Signature: _____ Date: ___/___/_____ (annual update)

I have reviewed the above and no changes are necessary:

Patient Signature: _____ Date: ___/___/_____ (annual update)

Sentara Martha Jefferson Medical Group

Financial Policy

Sentara Martha Jefferson Medical Group (SMJMG) is committed to providing each patient with the best possible medical care. The following information is provided to avoid any misunderstanding concerning payment for the professional services rendered by our practice.

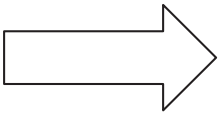
* Please note returned checks are subject to a $50.00 fee.

Insured Patients:

- Any required co-payments will be collected at the time of service.
- Upon receipt of a statement from our billing office, you will be responsible to pay any billed amounts unless other arrangements have been made.
- If your insurance plan determines a service not to be covered, we may bill you for that charge.
- If we do not have a contract with your insurance carrier, we will bill your insurance plan on your behalf.

You authorize us, our successors or assigns, to call you or contact you via electronic communication at any number you provide or at any number at which we reasonably believe we can contact you, including calls to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1)suspected fraud or identity theft; (2) obtaining information necessary or desirable; (3) your account transactions or servicing; and (4) collecting on your account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns.

Thank you for the opportunity to serve you. If you have questions regarding this information, please do not hesitate to ask. We are here to assist in any way we can.



Sentara Martha Jefferson Medical Group

ANNUAL CONSENTS, RELEASE OF INFORMATION, AND ASSIGNMENT OF INSURANCE BENEFITS

Consent to Treatment: I voluntarily consent to medical care at Sentara Martha Jefferson Medical Group, which may include examinations, tests, photographs, and treatment by physicians and other clinical staff. I understand that the general nature, purpose, risks and alternatives associated with any procedure or treatment will be explained to me by my doctor and, in the case of other services, by other physicians. I understand that I will have the opportunity at that time to ask for more information and to ask questions. I further understand that medical care and treatment is not an exact science. No promises have been made to me as to the results of examination or treatment.

Consent to Testing For Blood Borne Pathogens: Whenever any health care worker associated with or working for Sentara Martha Jefferson is directly exposed to bodily fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit human immunodeficiency virus (HIV or AIDS) or Hepatitis B and C, Sentara Martha Jefferson will proceed to test a sample of the patient's blood for the HIV (AIDS) virus or Hepatitis B and C. Sentara Martha Jefferson will also provide the results of the test to the patient through his or her physician and to the health care worker(s) who was/were exposed. In these circumstances, I understand that I will be deemed to consent to such testing. If there is a blood exposure from any healthcare worker, to any healthcare worker, or to me involving my bodily fluids, I consent and understand that a blood sample may be drawn and tested for Hepatitis B and C or the HIV (AIDS) virus for the protection of all concerned.

Notice of Virginia Prescription Monitoring Program Participation: This office participates in the Commonwealth of Virginia Prescription Monitoring Program for Controlled Substances and may access the computerized database to retrieve information on prescribed medications.

Protected Health Information: Sentara Martha Jefferson's Notice of Privacy Practices provides information about how Sentara Martha Jefferson and its providers may use and disclose my protected health information. The Summary Notice of Privacy Practices and the complete Notice of Privacy Practices is posted in the office. I acknowledge that I have the right to request a copy of the SMJMG Summary Notice of Privacy Practices and/or a complete copy of Sentara Martha Jefferson's Notice of Privacy Practices.

Release of Information, Assignment of Insurance Benefits and Financial Policy: I hereby authorize the release of pertinent information to my insurance company, CMS, and any other physicians involved in my care. I authorize insurance benefits to be paid directly to this office, realizing that I am responsible to pay for any non-covered services, non-covered co-payments, and non-covered co-insurances. I understand that if my account becomes delinquent, unpaid balances will be assigned to an outside collection agency. If all charges are not paid when due, the undersigned agree(s) to 33 1/3% attorney's fees, or collection agency fees, which shall be deemed incurred upon referral for collection, plus costs, and interest at the current rate applicable by Statute to Virginia Judgments. I have read, understand, and agree to the other terms included in the Sentara Martha Jefferson Medical Group Financial Policy.

Signature:

Patient's relationship to signer: ○ Patient ○ Spouse ○ Parent ○ Child ○ Guardian ○ Other _____

_____ _____ _____

Printed Name Signature Date

_____ _____

Patient's Printed Name (if different from above) Patient's DOB ◯ Patient is unable to sign or acknowledge

Created: 02/12/14 Revised: 07/14/16, 8/15/16 Owner: PSG dka