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 will be kept strictly confidential. Thank you.

Name _____ **Date** _____

Age _____ **Sex** _____ **Medical Doctor** _____

Height _____ **ft** _____ **in** **Weight** _____ **lbs** **Smoker** **Yes** / **No**

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
eCare Health Network

Patient Label

Consent for Treatment & Financial Agreement - SMJH & SMJMG

FIN

CONSENT FOR TREATMENT: Martha Jefferson Hospital; d/b/a Sentara Martha Jefferson Hospital or Martha Jefferson Medical Group, LLC. ("Sentara") accepts the above Patient for diagnostic testing, emergency or inpatient/outpatient treatment/surgery or telehealth services. The undersigned hereby consent(s) to Sentara providing its standard services, telehealth services and supplying or administering all services, supplies, medications (which may be dispensed from an alternate site pharmacy) and anesthesia ordered by Patient's or Sentara's physicians/assistants, and to the performance of all procedures they deem advisable, and to the disposal of removed tissues and the use of photography for clinical purposes.

FINANCIAL AGREEMENT: The undersigned agree(s) to pay all charges made by the Hospital based upon Sentara's current charge master and the charges of Martha Jefferson Medical Group, LLC. or medical providers at their current rate for services rendered and for supplies used in providing care and treatment to the patient. The undersigned understand(s) that any prepayment is for estimated charges only and agree(s) that the final bill may be different. Sentara is not in the business of extending credit. All charges shall be paid when due (within 30 days of initial billing.) The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If all charges are not paid when due, the undersigned agree(s) to pay 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. The return check fee is $25.00 and financial aid may be available to eligible individuals by calling the business office.

The Patient and the undersigned responsible parties are primarily liable for payment of Patient's account. Each of them authorizes and consents to Sentara and its agents use of any telephone number (including Cell Phone), email address or text number they provide or publish, to message or contact them regarding their accounts or health related information. It is acknowledge that the patient may opt out of such communication at any time. It is the patient/responsible party's sole responsibility to provide any proof of insurance within 3 days of each date of service and to comply in a timely manner with all requirements, and supply all information and documents necessary to obtain payment of benefits by any HMO or insurer, TRICARE, Medicare, Medicaid, Workers' Compensation carrier, governmental agency or other third-party source of benefits/payments. Sentara is not required to submit claims to such payees unless the patient supplies adequate insurance information for each account within timely filing guidelines. The undersigned understand(s) that the hospital fees, professional fees, for Emergency Physicians, Radiologists, Pathologists, and other physicians' services are billed separately. The undersigned agrees to pay for laboratory testing ordered for them by their physician, but performed in a Sentara reference laboratory. Should there be cumulative payments to Sentara in excess of the charges incurred for Patient's admission or treatment, it is agreed that the excess may be applied by Sentara to any of the Patient's outstanding accounts resulting from other Sentara admissions and/or treatments.

ASSIGNMENT OF BENEFITS from claims made by or on behalf of patients for any insurance coverage, workers' compensation, governmental agency or disability benefits, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest) due hereunder is made to Sentara and medical providers without offset. It is agreed that such ASSIGNMENTS SHALL NOT BE REVOKED. Hospital and medical providers are given a lien in like amount and are authorized to receive direct payment of all assigned benefits/proceeds. Any attorney, insurance carrier, responsible employer or agency handling or disbursing such benefits or proceeds is ordered, authorized and directed to withhold and promptly pay over to Hospital and medical providers the lesser of the full amount of their charges or the total net proceeds or benefits available without offset.

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immuno-deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Personal Valuables: The Hospital shall not be liable for loss of, or damage to, property not deposited with it for safekeeping.
(_____initials_____date)

Communication Assistance: I and/or my companion(s) have been offered Communication Assistance on this date.
Accepted (_____initials_____date) • **Declined** (_____ initials_____date)

Notice of Privacy Practices: I have been offered a copy of Sentara's Notice of Privacy Practices on this date.
Accepted (_____initials_____date) • **Declined** (_____ initials_____date)

Your Patient Rights and Responsibilities/Notice of Nondiscrimination I have been offered a copy of Sentara's Your Patient Rights and Responsibilities/Notice of Nondiscrimination on this date.
Accepted (_____initials_____date) • **Declined** (_____ initials_____date)

EACH UNDERSIGNED REPRESENTS THAT HE/SHE HAS READ AND FULLY UNDERSTAND THE MEANING AND EFFECTS OF THIS ENTIRE AGREEMENT, AND THAT SENTARA HAS MADE NO REPRESENTATION NOT HEREIN SET FORTH. CARBON COPIES AND PHOTOCOPIES HEREOF ARE DUPLICATE ORIGINALS FOR ALL PURPOSES.

Date/Time	Patient Signature	Other responsible party signature	Relationship

☐ No Responsible Person Available (If checked, two witness signatures required.)
☐ Patient unable to sign but has acknowledged an understanding of the above and consents to the undersigned witness printing his/her name.
☐ Verbal consent to treat obtained from responsible party_____.

Employee Witness Signature	Date / Time	Employee Witness Signature	Date / Time