

Mechanicsville Medical Center Family Practice

Date: _____

PATIENT INFORMATION

Thank you for choosing our practice! In order to provide you with your medical care and to comply with new Federal HIPAA laws, we need the following information.

Patient Name: First: _____ M.I.: _____ Last: _____ Suffix: _____

Date of Birth: _____ (Jr., Sr., II, III)

Gender: Male Female

Marital Status: Married Single Divorced Legally separated Widowed

Race: Black White

Ethnicity: African American Australian Eastern European Pacific Islander
 American Austrian European Hispanic
 Arabian Bavarian Filipino Irish
 Asian Indian British French Italian
 American Indian Chinese German Japanese
 Asian Korean

Preferred Language: English Other

Social Security #: _____

Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

E-Mail Addresses: (1) _____ (2) _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance: Insurance Carrier Name: _____

Subscriber Name: _____ Relationship to Patient: Self Spouse

SS#: _____ Date of Birth: _____ Child Other

Secondary Insurance: Insurance Carrier Name: _____

Subscriber Name: _____ Relationship to Patient: Self Spouse

SS#: _____ Date of Birth: _____ Child Other

Authorization, Release, and HIPAA Notice of Privacy Practices certification:

I hereby authorize release of any information concerning my, or my child's or my legal guardianship's, health care pursuant to the terms of the "Notice of Privacy Practices". I hereby assign to MMCFP any and all health care benefits to which I am entitled under any insurance policy and authorize, to the extent permitted by law, payment of those benefits directly to MMCFP, only up to the amount of any balance due for services. Any co-pays, deductibles, co-insurance, or charges not covered by insurance that I agree to have performed in advance will be paid at the time of service. If any collection activities are pursued all costs associated with this will be borne by me. By signing below I certify that I have been given a copy of the "Notice of Privacy Practices".

X _____
Signature of Patient, Parent/Guardian of Patient, if a minor Date

____ Please initial if you **DO NOT** want us to leave information on your answering machine.