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:_____

(Jr., Sr., II, III)

Date of Birth: _____

Gender at birth: [ ] Male [ ] Female **Gender Identity**: [] Male [] Female [] Non-binary

Marital Status: [ ]Married [ ] Single [ ]Divorced [ ] Legally separated [ ] Widowed

Race: [ ] Black [ ] White [ ] American Indian [ ] Asian [ ] Pacific Islander

Ethnicity:

[ ] African American	[ ] Chinese	[ ] Hispanic	[ ] Mexican
[ ] American	[ ] European	[ ] Irish	[ ] Polish
[ ] Asian Indian	[ ] Filipino	[ ] Italian	[ ] Russian
[ ] Australian	[ ] French	[ ] Japanese	[ ] Other
[ ] British	[ ] German	[ ] 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.