LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

**Family Allergy & Asthma Associates**

**19465 Deerfield Ave., Ste. 301**

**Lansdowne, VA 20176**

**(703) 729-1723**

## DEMOGRAPHICS

| | | |
|---|---|---|
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| SOCIAL SECURITY NUMBER | SEX | PREFIX/SUFFIX |
| DATE OF BIRTH *(mm/dd/yy)* | STATUS *(please circle one)*<br>Single Married Divorced Widowed Partner | STUDENT *(please circle one)*<br>☐ No ☐ Full Time ☐ Part Time |
| STREET ADDRESS | CITY/STATE | ZIP CODE |
| HOME PHONE *(include area code)* | WORK PHONE | CELL PHONE |
| RACE *(please circle one)*<br>White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native | ETHNICITY *(please circle one)*<br>Hispanic or Latino Not Hispanic or Latino Unknown | PREFERRED LANGUAGE<br>☐ English ☐ Spanish<br>Or other: _____ |

| | | | |
|---|---|---|---|
| EMPLOYER | JOB TITLE/STATUS | EMPLOYER ADDRESS | EMPLOYER PHONE NUMBER |
| PREFERRED PHARMACY | PHARMACY PHONE NUMBER | EMAIL ADDRESS | |

## CONTACT/GUARANTOR INFORMATION

| | | | |
|---|---|---|---|
| CONTACT *(please circle at least one)*<br>Emergency Contact Next of Kin Insured Authorized to Seek Treatment | LAST NAME | FIRST NAME | MIDDLE INITIAL |
| SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)* | RELATIONSHIP TO PATIENT | SEX | MARITAL STATUS |
| HOME ADDRESS | CITY/STATE | ZIP CODE | HOME PHONE |
| EMPLOYER | WORK PHONE | JOB TITLE | |

**If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.**

| | | | |
|---|---|---|---|
| CONTACT *(please circle at least one)*<br>**Guarantor**<br>Emergency Contact Next of Kin Insured Authorized to Seek Treatment | LAST NAME | FIRST NAME | MIDDLE INITIAL |
| SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)* | RELATIONSHIP TO PATIENT | SEX | MARITAL STATUS |
| HOME ADDRESS | CITY/STATE | ZIP CODE | HOME PHONE |
| EMPLOYER | WORK PHONE | JOB TITLE | |

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## INSURANCE POLICY INFORMATION

| POLICY NUMBER | GROUP ID | | EFFECTIVE DATE |
|---|---|---|---|
| TYPE (please circle one only)<br>Health Auto Work. Comp.<br>Other | PRIMARY INSURANCE?<br>☐ Yes ☐ No | END DATE | COPAYMENT AMOUNT<br>Office: $_____ Specialist: $_____ |
| NAME OF INSURANCE COMPANY/PLAN | INSURANCE COMPANY ADDRESS | | PHONE NUMBER |
| INSURED'S NAME | DATE OF BIRTH *(mm/dd/yy)* | | HOME PHONE |
| INSURED'S MAILING ADDRESS | PRIMARY CARE PHYSCIAN (PCP) | | REFERRING PHYSICIAN |

## SECONDARY INSURANCE INFORMATION (if applicable)

| POLICY NUMBER | GROUP ID | | EFFECTIVE DATE |
|---|---|---|---|
| TYPE (please circle one only)<br>Health Auto Work. Comp.<br>Other | PRIMARY INSURANCE?<br>☐ Yes ☐ No | END DATE | COPAYMENT AMOUNT<br>Office: $_____ Specialist: $_____ |
| NAME OF INSURANCE COMPANY/PLAN | INSURANCE COMPANY ADDRESS | | PHONE NUMBER |
| INSURED'S NAME | DATE OF BIRTH *(mm/dd/yy)* | | HOME PHONE |

**I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.**

_____ _____

**Print Name** **Date**

_____

**Signature**

## NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it

_____ _____

**Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis** **Date**

_____

**Relationship (if signature is not of Patient)**
**Signature of Person Obtaining Consent**

**Submit Form to FAAA**