DO NOT WRITE IN GRAY AREA

PATIENT INFORMATION

TODAY'S DATE ________

GRAY AREA FOR OFFICE USE ONLY

1. RESPONSIBLE PARTY NAME: ________ LAST ________ FIRST ________ MIDDLE DOB: ________
2. PATIENT NAME: ________ LAST ________ FIRST ________ MIDDLE
3. ADDRESS: ________ NUMBER ________ STREET
4. ADDRESS: ________
5. ADDRESS: ________ CITY ________ STATE 6. ZIP: ________
7. HOME PHONE: ________ 8. BUSINESS PHONE: ________ 9. EXTENSION ________

CELL PHONE: ________

10. PHARMACY NAME: ________ 11. EMAIL ADDRESS: ________

PHONE#: ________

12. SOCIAL SECURITY NUMBER (PATIENT)	AGE	13. BIRTHDAY DATE (MONTH / DAY / YEAR)

14. SEX	15. MARITAL STATUS	16. PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY
M - MALE F - FEMALE	1 - MARRIED 2 - SINGLE 3 - DIVORCED 4 - WIDOWED 5 - SEPARTED	1 - SELF 2 - SPOUSE 3 - CHILD 4 - DEPENDENT 5 - OTHER

EMPLOYER: ________ NAME

________ ADDRESS OCCUPATION: ________

SPOUSE NAME: ________ DOB: ________ SPOUSE EMPLOYER: ________

I HEREBY AUTHORIZE DR. ________ TO FURNISH INFORMATION TO INSURANCE CARRIES CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE DOCTORS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT.

(SIGNATURE) PARENT OR PATIENT/GUARDIAN X ________

Acknowledgment of Receipt of Privacy Practices

I, ________ have received a copy of Central Virginia OB/Gyn Group's Notice of Privacy Practices with an effective date of ________.

Signature of Patient ________ Date ________

Name of Witness ________

Signature of Witness ________ Date ________