

Patient Information



Patient Information	Last Name		First	Middle Initial	Social Security No.	
	Address			City	State	Zip Code
	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Birthdate / /	Age	Occupation	Employer
	Home Phone		Work Phone		Cell Phone	
	Email Address:			Preferred Contact Method:		
Responsible Party	Race <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American			Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline		Preferred Language <input type="checkbox"/> Decline
	Emergency Contact Name		Relationship		Phone	
	Responsible Party - Last Name		First	Middle Initial	Birthdate / /	Social Security No.
	Address			City	State	Zip Code
	Home Phone		Work Phone		Cell Phone	
Privacy	HIPAA Acknowledgements: All patients must initial all that apply: I hereby acknowledge that I have been provided with a copy of the Bayview Physicians Group Notice of Privacy Policies. Is it ok to leave a message regarding your health information at your : <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> No Messages Initials: _____ By default, no other persons may have access to my medical record except the following people:					
	Name & Relationship					
	For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.					
Insurance	Insurance Co. #1		Insurance Co. #2			
	Company Name		Company Name			
	ID No.	Group No.	ID No.	Group No.		
	Subscriber's Name		Date of Birth		Subscriber's Name	Date of Birth
Relation to Patient		SS#:	Relation to Patient		SS#:	
Consent, Agreements & Signature	Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - No Guarantee Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed. I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as an testing and/or treatment carried out by Bayview Physician Services, PC staff under the direction of the Medical Director. I agree that Bayview Physicians Group may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not share your information. You can opt out at anytime. Chaperones will be present during certain examinations. Any request for a chaperone made by a patient and/or family member will be honored. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment.					
	Financial Agreement - Insurance Agreement I hereby authorize treatment to patient by any Bayview Physicians Group provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute as covered services, including denied Worker's Compensation claims, as well as attorney fees of 33 1/3% and other related costs of collection should such action become necessary.					
	Signature of Patient/Responsible Party		Relationship to Patient		Date	