

# Patient Registration

13895 Hedgewood Drive, Suite 101  
Woodbridge, VA 22193  
Tel: 703-649-3803, Fax 703-546-4259



## Patient Information

First Name		Middle Name		Last Name	
Address		City	State	Zip	
Home Phone		Cell Phone		Email	
Social Security Number		Date of Birth	Primary Care Physician (if any)		Primary Care Phone
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student	Race <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Dominant Hand <input type="checkbox"/> Right <input type="checkbox"/> Left				Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	
How did you hear about us? <input type="checkbox"/> Another Patient <input type="checkbox"/> My Insurance <input type="checkbox"/> Google/Web Search <input type="checkbox"/> Yellow Pages <input type="checkbox"/> YP.COM <input type="checkbox"/> Superpages.com <input type="checkbox"/> Other _____					

## Employer Information

Employer	Occupation	Work Phone	
Employer Address	City	State	Zip

## Insurance and Pharmacy Information

Bill Insurance <input type="checkbox"/> Insurance Card provided <input type="checkbox"/> Cash only	Your Preferred Pharmacy
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## Insurance Policy Holder (Skip this section if patient is the policy holder)

Last Name	First Name	Middle Init	Relationship to patient
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Social Security #	Date of Birth	Gender	

## Emergency Contact

Last Name	First Name	Middle Init	Relationship to patient
Home Phone	Cell Phone	Work Phone	

### Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to One Care Medical of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance including all attorneys' fees, collection agency fees, and other costs incurred should One Care Medical have to institute collection efforts. I authorize payment of medical benefits, which would otherwise be payable to me, to One Care Medical for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct. I authorize the transfer of monies paid to One Care Medical by or on behalf of the Patient and otherwise refundable to the Patient or Guarantor, to other accounts at this facility or any other One Care Medical entity for which the Patient or Guarantor is responsible.

### Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment (Treatment) from the physicians and staff at One Care Medical. I consent to any necessary lab work, including HIV testing. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date