L O U D O U N P E D I A T R I C A S S O C I A T E S

Patient/s Information

(Please include all children currently with the practice)

Last Name	First Name	Date of Birth	Race /Ethnicity	Sex
Last Name	First Name	Date of Birth	Race /Ethnicity	Sex
Last Name	First Name	Date of Birth	Race /Ethnicity	Sex
Last Name	First Name	Date of Birth	Race /Ethnicity	Sex
Last Name	First Name	Date of Birth	Race /Ethnicity	Sex

Email (Required for access to Patient Portal)

Parent/Legal Guardian Information

First and Last Name	Relation to Patient/s	Home Phone	Cell Phone	Work Phone
Mailing Address		City/State		Zip Code

First and Last Name	Relation to Patient/s	Home Phone	Cell Phone	Work Phone
Mailing Address		City/State		Zip Code

Primary Insurance Information

(A physical, printed copy of the card must be presented at each visit)

Insurance Policy Holder's Name	Policy Holder's Date of Birth	Relation to Patient/s	
Insurance Company Name		PCP (if applicable)	
Policy/ID Number	Group Number	Effective Date	Copay Amount

Non-Parent/Non-Legal Guardian Emergency Contact Information

First and Last Name	Relation to Patient/s:	Home Phone	Cell Phone	Is this person authorized to seek treatment for your child/children? YES / NO

Patient Authorization

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 Loudoun Medical Group, PC (LMG) or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC, or any of its affiliates. I agree to promptly pay for services rendered for me or the patient/s named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time. I 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 Occupation Safety and Health Administration.

_____ _____

Signature **Date**