SENTARA®

Sentara Medical Group

Patient Registration Form

Last Name_____ First Name_____ MI____

Preferred Name_____ Previous Last Name(s)_____

Social Security # | | | | | | | | | | Date of Birth____/____/____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed

Home Address _____

_____

City_____ State_____ Zip Code_____

Home Phone(____)_____ Cell Phone(____)_____

Alternate Phone(____)_____ E-Mail_____

Patient/Family Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Alt Phone ☐ E-Mail ☐ Text

Primary Care Physician_____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Hispanic ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Other Race – Please Print_____

☐ Two or More Races – Please Print_____

Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

☐ Other/Unknown – Please Print if Other_____

Language Preference: If other than English- Please Print_____

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication?

If yes, Please check appropriate item(s): ☐ Vision ☐ Hearing

Employer Name_____

Address_____

City_____ State_____ Zip Code_____

Work Phone Number(____)_____ Ext_____

Emergency Contact - Who to call in the event of an Emergency

1. Name_____ Relationship_____

   Phone Number(____)_____

2. Name_____ Relationship_____

   Phone Number(____)_____

Is your visit due to a job related injury or automobile accident? ☐ Yes ☐ No

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) ☐ Yes ☐ No

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients ☐ Guarantor? ☐ Legal Guardian?

Guarantor/Legal Guardian Name_____ Social Security # | | | | | | | | | |

Patient's Relationship to Guarantor/Legal Guardian: ☐ Spouse ☐ Dependent Child ☐ Student

☐ Other – Please Print_____

Guarantor/Legal Guardian Home Address_____

_____

City_____ State_____ Zip Code_____

Home Phone(____)_____ Cell Phone(____)_____

Guarantor/Legal Guardian Employer Name_____

_____

City_____ State_____ Zip Code_____

Work Phone Number(____)_____ Ext_____

Primary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Primary Insurance***

Plan Name_____

Policy Holder Name_____ Gender: ☐ Male ☐ Female

Policy Holder's Social Security # | | | | | | | | | | Policy Holder Date of Birth_____

Secondary Insurance Information - ***Please complete the below information if the patient is not the Policy Holder for the Secondary Insurance***

Plan Name_____

Policy Holder Name_____ Gender: ☐ Male ☐ Female

Policy Holder's Social Security # | | | | | | | | | | Policy Holder Date of Birth_____

Disclosure to Family Members and Friends - Please list any person(s) that you would like to grant permission to your provider to discuss your Medical Record and/or Plan of Care? If so, please complete the below information.

1. Name_____ Relationship_____

   Phone Number(____)_____ Cell Number (____)_____

2. Name_____ Relationship_____

   Phone Number(____)_____ Cell Number (____)_____

3. Name_____ Relationship_____

   Phone Number(____)_____ Cell Number (____)_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary.

Patient/Guarantor Printed Name_____

Patient/Guarantor Signature_____ **Date**_____