

Olde Towne Medical Center  
Patient Registration

PCP: _____
Appt Date _____
Prepay\$ _____

Please Print

Chart# \_\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: (circle) Male Female **Employed:** (circle) Full-time Part-time Retired Student

Employer/School: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Email: \_\_\_\_\_ **Marital Status:** (circle) Single Married Widow(r) Divorced

**Race:** (circle) Caucasian Black/African American Hispanic Asian American Indian Other

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you a United States Citizen? (circle) Yes No

**Spouse or Parent or Guardian Information**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

**Payment Information** Please check all that apply and have all cards available for copying:

**Medicare#:** \_\_\_\_\_ **Medicaid/Healthkeepers/Optima#:** \_\_\_\_\_ **Sliding Fee (Page 2)**

**Certification** I certify that the information given on this registration form is correct to the best of my knowledge.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

\*Patient, Guardian and /or Financial Guarantor

\*If patient is a minor or an incompetent adult, signature must be (1) spouse: (2) guardian: (3) parent or known representative.

**Please circle your county of Residence:**

- |              |                 |                      |              |
|--------------|-----------------|----------------------|--------------|
| Charles City | James City      | City of Williamsburg | Surry        |
| Gloucester   | Newport News    | New Kent             | Other: _____ |
| Hampton      | York / Yorktown | King & Queen         |              |



Olde Towne Medical Center  
**Consent for Treatment / Assignment of Benefits**

I give my permission and consent for the treatment of \_\_\_\_\_ by the physicians and employees of Olde Towne Medical Center. I request that payment Medicare or other insurance benefits be made on my behalf to Olde Towne Medical Center and authorize the release of medical information to requesting insurance companies or government agencies to determine those benefits. I also authorize release of medical information to any requesting doctors as necessary. I understand that regardless of insurance coverage, payment for services rendered is my responsibility and I agree to pay all expenses incurred in the collection of delinquent amounts, without insurance coverage from companies with which we participate is required at the time of visit unless alternate arrangements are made in advance.

I am responsible for presenting my card to Olde Towne Medical Center if I become insured or my insurance changes to a new plan. I am responsible for notifying OTMC of the change at the time of the visit. Without an insurance card, I understand I have 30 days to provide OTMC with the insurance information, or I will be responsible for payment in full for service received and/or products purchased.

I understand that the services I receive may not be a covered benefit of my health insurance plan. I agree to be responsible for payment for services received and/or products purchased if these benefits are not covered by my insurance plan.

I understand that it is my responsibility to call my PCP to request a referral authorization, if the reason for my appointment requires one. I agree to call my doctor with this request prior to the visit or within 24 hours after the visit. I agree to be responsible for payment of services if my PCP does not grant a referral.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

A Law was enacted in VA in 1989 which authorized health care providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the health care provider is exposed to the body fluid of a patient in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies or Hepatitis B or C viruses pursuant to the provision, the test would be explained, and you would be given the opportunity to ask any questions you may have. Please note that this is not consent to draw your blood. The purpose of this is to inform you of the Virginia law.

I have read and understand the above "Notice of Deemed Consent to HIV and Hepatitis B or C Testing".

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You have been given an appointment for health care at OTMC. This is valuable time for you and for the staff at the center. If you must cancel any appointments, please call OTMC (259-3258) one day in advance. If you do not come to an appointment, or if you are more than 15 minutes late, you may receive one other appointment. If you do not come to the second appointment, you will not be given another appointment until the Executive Director and/or Medical Director have given approval.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date