



PATIENT INFORMATION

Personal Information\*

Prefix: Mr./Mrs./Other: Patient Name\*: Suffix: Jr./Sr./Other:

Previous Name: Preferred Name: Email:

Mailing Address\*:

Home #: Cell #: Work #: Ext: City State Zip

Method of Contact for Appointment Reminders: Text Message Home Phone Cell Phone

Primary Care Provider (PCP): Address: Phone #:

Referring Provider: Address: Phone #:

Date of Birth\*: Birth Sex\*: Marital Status\*: Single Married Widowed Separated Divorced

Social Security #: Employer Name: Occupation:

Employment Status: Full Time Part Time Not Employed Self Employed Retired Active Military Unknown

Student Status: Full Time Part Time N/A

Additional Information\*

Race\*: Caucasian/White Asian Black/African American Hawaiian/Pacific Islander Other:

Ethnicity\*: Hispanic/Latino Non-Hispanic or Latino

Gender Identity: Male Female Female-To-Male (FTM)/Transgender Male/Trans Man Male-To-Female (MTF)/Transgender Female/Trans Woman Genderqueer, neither exclusively male nor female Choose not to disclose Other, please specify:

Language\*: English Spanish Other:

Sexual Orientation: Lesbian, gay/homosexual Straight/heterosexual Bisexual Don't know Choose not to disclose Something else:

Pharmacy Name\*: Address: Phone #:

Emergency Contact\*

Name: Relationship:

Address: Street Address Apt # City State Zip

Home #: Work #: Cell #:

Parent / Guardian Information\* - Required if the patient is under 18 years of age

Name: Date of Birth: Birth Sex: Social Security #:

Address: Street Address Apt # City State Zip

Home #: Cell #: Work #: Ext:

Primary Insurance Information\*

Insurance Name: Member ID #: Relationship to Insured:

Employer: Group #: Effective Date: mm/dd/yyyy

Insured's Information\* - (if not self)

Name: Date of Birth: Birth Sex: Social Security #:

Relationship to Insured: Marital Status\*: Single Married Widowed Separated Divorced

Address: Street Address Apt # City State Zip

Home #: Work #: Cell #:

Secondary Insurance Information

Insurance Name: Member ID #: Relationship to Insured:

Group #: Effective Date:

Secondary Insured's Information - (if not self)

Name: Date of Birth: Birth Sex: Social Security #:

Relationship to Insured: Marital Status\*: Single Married Widowed Separated Divorced

Address: Street Address Apt # City State Zip

Home #: Work #: Cell #:

## CONSENT INFORMATION

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 LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also 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 Occupational Safety and Health Administration.  \_\_\_\_\_ (Please initial)

### NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed.  \_\_\_\_\_ (Please initial)

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.  \_\_\_\_\_ (Please initial)

### CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

#### Opt In: Send and Receive Documents

\_\_\_\_\_ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

#### Opt Out

\_\_\_\_\_ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

### MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program.  \_\_\_\_\_ (Please initial)

\_\_\_\_\_  
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship (if any)