MOUNTAIN VIEW
Medical Associates

## DEMOGRAPHICS

| | | |
|---|---|---|
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| SOCIAL SECURITY NUMBER | SEX | PREFIX/SUFFIX |
| DATE OF BIRTH | STATUS (PLEASE CIRCLE)<br>Single Married Divorced Widowed Partner | STUDENT (PLEASE CIRCLE)<br>No Full-Time Part-Tim |
| STREET ADDRESS | CITY/STATE | ZIP CODE |
| HOME PHONE | WORK PHONE | CELL PHONE |
| RACE (PLEASE CIRCLE)<br>White Black/African Amer Asian<br>Hawaiian/Other Pacific Island<br>Other race/American Indian/Alaska Native | ETHNICITY (PLEASE CIRCLE)<br>Hispanic or Latino Not Hispanic or Latino<br>Other | PREFERRED LANGUAGE<br>English Spanish<br>Other _____ |
| EMPLOYER | JOB TITLE / STATUS | EMPLOYER ADDRESS |
| EMPLOYER PHONE NUMBER | PREFERRED PHARMACY (NAME AND LOCATION) | EMAIL ADDRESS |

## CONTACT/GUARANTOR INFORMATION

| | | |
|---|---|---|
| CONTACT<br>Emergency Contact Next of Kin<br>Insured Authorized to Seek Treatment | LAST NAME | FIRST NAME, MIDDLE INITIAL |
| SOCIAL SECURITY/DATE OF BIRTH | RELATIONSHIP TO PATIENT | SEX MARITAL STATUS |
| HOME ADDRESS | CITY/STATE | ZIP CODE |
| HOME PHONE | EMPLOYER / JOB TITLE | WORK PHONE |

## INSURANCE POLICY INFORMATION

| | | |
|---|---|---|
| POLICY NUMBER | GROUP ID | EFFECTIVE DATE |
| TYPE (PLEASE CIRCLE)<br>Health Auto Work Comp Other | PRIMARY INSURANCE<br>Yes No / END DATE | COPAYMENT AMOUNT |
| NAME OF INSURANCE COMPANY/PLAN | INSURANCE COMPANY ADDRESS | PHONE NUMBER |
| INSURED'S NAME | DATE OF BIRTH | HOME PHONE |
| INSURED'S MAILING ADDRESS | PRIMARY CARE PHYSICIAN | |

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, healthy maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC or any of its affiliates or agents, lends, or any third party servicer acting for LMG, PC or any of it affiliates

_____ _____

PRINT NAME DATE

_____

SIGNATURE

How did you hear about our practice? (circle one) FRIEND FAMILY MEMBER PURCELLVILLE GAZETTE
LEESBURG TODAY INSURANCE COMPANY OTHER _____