CENTRAL VIRGINIA HEALTH SERVICES

NEW PATIENT REGISTRATION FORM

CVHS ACCT: _____

PATIENT INFORMATION

Last Name, Suffix:	First Name:	Middle Initial:
Mailing Address:		
Street Address (if different from mailing address):	City:	State: / Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Date of Birth: ____/____/_____ / Sex:	Social Security:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated
Patient's Email:	Preferred Pharmacy:	

RESPONSIBLE PARTY (GUARANTOR) ☐ Self (if self, leave blank) ☐ Parent/Legal Guardian ☐ Spouse

First Name:	Middle Initial:	Last Name, Suffix:
Mailing Address:	City: / State: / Zip Code:	
Guarantor's Date of Birth:	Guarantor's Social Security:	Guarantor's Sex: / Guarantor's Phone Number:
Emergency Contact:		
Relationship:	Telephone Number:	

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

The new government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency.

Please list your choice of individuals for us to disclose/discuss your private health information. Please list those you authorize (I.e.: spouse, children, sibling or caregiver) and remember that even your spouse needs to be listed if it is okay for us to speak with them.

Name:	DOB: ____/____/_____	Phone:	HIPPA: (Circle one) Yes or No
Mailing Address:	City	State: / Zip Code:	

Tell us where to call you, leave messages, and appointment reminders: ☐ Home ☐ Cell ☐ Work

Can CVHS leave messages on the phone numbers you have provided? ☐ Yes ☐ No If yes, may we leave:

Brief messages with NO clinical information, *OR* ☐ Yes ☐ No

Extended messaged with some clinical information ☐ Yes ☐ No

Please choose one

EMPLOYER INFORMATION	
Employer Name:	Employer Address:
Can we leave a message at work?: ☐ Yes or ☐ No If yes, (circle one): Brief or Descriptive	

INSURANCE INFORMATION		
Name of primary medical insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Name of dental insurance:	Policy Subscriber's name (if not patient):	Policy Subscriber DOB: ____/____/_____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify _____		

As a medical center that receives some federal funding, the following information will help us tailor our services to better meet your needs and to obtain grants and other funds to continue improving our practice. Thank you in advance for your assistance.

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Other Pacific Islander ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian ☐ Alaska Native ☐ Other Race ☐ Unreported/Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to report

Language: ☐ English ☐ Spanish ☐ Other	Translator: ☐ Yes ☐ No
Are you a veteran?: ☐ Yes ☐ No Are you migrant?: ☐ Yes ☐ No Are you limited in English Proficiency?: ☐ Yes ☐ No	Are you a seasonal worker?: ☐ Yes ☐ No Are you homeless?: ☐ Yes ☐ No Are you in Public Housing?: ☐ Yes ☐ No
Gender Identity: ☐ Male ☐ Female ☐ Transgender male (female to male) ☐ Transgender female (male to female) ☐ Other ☐ Choose not to disclose	Sexual Orientation: ☐ Straight ☐ Bisexual ☐ Lesbian or gay ☐ Something else ☐ Choose not to disclose ☐ Don't know

Please read the items below and initial beside each item, then sign and date as noted.	Initial
PRIVACY PRACTICE: I have read and understand the CVHS "Notice of Privacy Practices"	
COLLECTIONS POLICY: I have read and understand the CVHS "Collection Policy"	
INSURANCE: I authorize CVHS to furnish information to my insurance company regarding my health or healthcare or dental care. I assign CVHS to receive payment from insurance claims filed by CVHS for medical/dental services. I understand that I am responsible for the payment of all fees. I also understand that I am ultimately responsible for making sure my insurance will cover appointments with CVHS and with specialists to who I am referred by CVHS providers.	

Please have your insurance card available at check in.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

How did you hear about CVHS? ☐ Family/Friend ☐ Newspaper ☐ Internet ☐ Other (specify): _____