LEE - DAVIS
MEDICAL CENTER
INTERNAL MEDICINE
7041 LEE PARK ROAD • MECHANICSVILLE, VIRGINIA 23111-3682

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

SOCIAL SECURITY #: _____/_____/_____ DATE OF BIRTH: _____/_____/_____ SEX: ❒ MALE ❒ FEMALE

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ SEPARATED ❒ DIVORCED ❒ WIDOWED

HOME ADDRESS: _____ CITY, STATE, ZIP: _____

HOME TELEPHONE: _____ EMPLOYER: _____ EMPLOYER TELEPHONE: _____

YOUR PHYSICIAN: ❒ DR. CAPPELLO ❒ DR. JANNEY ❒ DR. OVERMEYER ❒ DR. ROBERTS ❒ DR. PAYNE ❒ DR. KIRBY

DID ANOTHER PHYSICIAN REFER YOU TO US?: ❒ YES ❒ NO IF YES, WHO? _____

RESPONSIBLE PARTY INFORMATION

IF THE PATIENT IS OVER THE AGE OF 18, THE PATIENT IS RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THEIR INSURANCE CARRIER. IF THE PATIENT IS UNDER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PATIENT OR HIS OR HER GUARDIAN AND PROVIDE US WITH A PHOTO IDENTIFICATION OF THE PATIENT.

RESPONSIBLE PARTY'S LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: ___

BILL TO ADDRESS: _____ CITY, STATE, ZIP: _____

HOME TELEPHONE: _____ EMPLOYER TELEPHONE: _____ EXT: _____

INSURANCE INFORMATION

FOR THE PROPER ALLOCATION OF YOUR INSURANCE BENEFITS., PLEASE PRESENT YOUR INSURANCE CARD(S) AND A PHOTO IDENTIFICATION TO THE RECEPTIONIST. IF YOUR RESPONSE TO ANY OF THE FOLLOWING QUESTIONS IS "SAME", PLEASE WRITE "SAME".

NAME OF PRIMARY INSUIRANCE CARRIER: _____

SUBSCRIBER'S NAME: _____ SEX: ❒ MALE ❒ FEMALE DATE OF BIRTH: _____/_____/_____

RELATIONSHIP: _____ SUBSCRIBER'S SOCIAL SECURITY #: _____ DEDUCTIBLE: _____ CO-PAYMENT: _____

NAME OF SECONDARY INSUIRANCE CARRIER: _____

SUBSCRIBER'S NAME: _____ SEX: ❒ MALE ❒ FEMALE DATE OF BIRTH: _____/_____/_____

RELATIONSHIP: _____ SUBSCRIBER'S SOCIAL SECURITY #: _____ DEDUCTIBLE: _____ CO-PAYMENT: _____

EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT: _____ TELEPHONE #: _____

YOUR CELL PHONE #: _____ HOW DID YOU HEAR ABOUT LEE-DAVIS MEDICAL CENTER? _____

SIGNATURES

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____