ADVANCED E·N·T Specialists
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LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please circle one)* Single Married Divorced Widowed Partner	STUDENT *(please circle one)* No Full Time Part Time
STREET ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELL PHONE
RACE *(please circle one)* White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native	ETHNICITY *(please circle one)* Hispanic or Latino Not Hispanic or Latino Unknown	PREFERRED LANGUAGE English Spanish Or other: _____

EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
PREFERRED PHARMACY	PHARMACY PHONE NUMBER	EMAIL ADDRESS	

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle at least one)* Emergency Contact Next of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME		MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS	
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE	
EMPLOYER	WORK PHONE	JOB TITLE		

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please circle at least one)* **Guarantor** Emergency Contact Next of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME		MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS	
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE	
EMPLOYER	WORK PHONE	JOB TITLE		

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSCIAN (pcp)		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

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.

_____

Print Name

_____

Signature

_____

Date