Dermatology Center of Williamsburg
5335 Discovery Park Blvd, Suite A
Williamsburg, Va 23188
(757)-645-3787 Fax # (757)-645-3774

Patient Registration:
Date_____ Soc.Sec#_____ Birthday_____
Name_____ Home Phone_____
Last Name First Name Middle initial
Address_____ Cell Phone_____
City_____ State_____ Zip Code_____ Email_____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Race: Caucasian African American Hispanic Asian American Other:_____
Employer_____ Business Phone_____
Business Address_____ Occupation_____
Who should we thank for referring you?_____
In Case of emergency, who should we contact_____ Phone_____

PRIMARY INSURANCE:
Person Responsible for Account_____
Last Name First Name Middle Initial
Relationship to Patient_____ Birthday_____ Soc Sec#_____
Address_____ Phone Number_____
City_____ State_____Zip Code_____
Responsible Party Employed By_____Business Phone_____
Insurance Company_____
Subscriber ID#_____Group Number_____

ADDITIONAL INSURANCE:
Insured Name_____
Last Name First Name Middle Initial
Relationship_____Birthday_____Soc. Sec#_____
Address_____ Phone Number_____
City_____State_____Zip Code_____
Insured Employed By _____Business Phone_____
Insurance Company_____
Subscriber ID#_____Group Number_____

ASSIGNMENT AND RELEASE:
I hereby authorize payment directly to Dermatology Center Of Williamsburg for all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and /or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Patient Signature:_____ Date_____

Notice of Deemed Consent for HIV/Hepatitis Testing:
A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies and hepatitis, when the health care provide is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such and exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies and hepatitis antigen pursuant to this provision, the testing would be explained and you would be given the opportunity to ask any questions you might have.
I have read and understand the above "Notice of Deemed Consent for HIV/Hepatitis Testing". _____Initial