Virginia Rheumatology Clinic

516 Innovation Drive, Suite 204
Chesapeake, VA 23320
Phone: 277-9927
Fax: 277-9928

Date: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Seperated ○ Widowed **Language:** _____

Sex: ○ Male ○ Female **Race**: _____ **Ethnicity**: Hispanic / Non Hispanic

Name: _____ **DOB**: _____
Last First MI

Address: _____

City: _____ State:_____ ZIP: _____

SSN: _____ **Home Phone**: _____

Email: _____ **Cell Phone**: _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact: _____ Phone: _____

1) **Primary Insurance:** _____

Subscriber Name: _____ Subscriber's DOB:_____

Relationship to Patient: _____ Subscriber's SS# _____

Insurance ID#: _____ Group #:_____ Co-Pay:_____

2) **Secondary Insurance:** _____

Subscriber Name: _____ Subscribers DOB: _____

Relationship to Patient: _____ Subscriber's SS# _____

Insurance ID#: _____ Group #:_____ Co-Pay:_____

Please list the physicians you see and their specialty:

Primary Care Physician Name: _____

Primary Care Phone Number: _____

Preferred Pharmacy Name: _____ Address/Phone:_____

_____

Signature of Patient

This is an Authorization for Treatment. I understand I am responsible for any amount not paid by my insurance.