Chase City Primary Care Center, Chase City, VA

A Service of VCU Community Memorial Hospital

(**PLEASE PRINT CLEARLY)**

Patient Registration

Patient's Name: _____ **Social Sec. #:** _____

Date of Birth: _____ Primary Phone #: _____ Secondary Phone #: _____

Please circle one **Home Cell Business** **Home Cell Business**

Race _____ **Ethnicity:** ☐ **Hispanic** ☐ **Not Hispanic**

Male ____ Female ____ Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Preferred Pharmacy: _____

Mailing Address: _____ City, State: _____ Zip_____

911 Address: _____ City, State: _____ Zip_____

Patient's Employer: _____ Work Phone #: _____

Spouse's Name: _____ Social Sec. #: _____

Spouse's Employer: _____ Work Phone #: _____

Email Address: _____

Responsible Party: _____ Relationship **to Patient**: _____

In Case of emergency, contact: _____ Ph. # w/ Area Code: _____

If patient is a Minor, are parent's ___ Married ___ Divorced - Custodial Parent: _____

Custodial Parent Home Ph. w/Area Code: _____ Work Ph. w/Area Code _____

Custodial Parent SS #: _____ Date of Birth: _____

Is this a work-related visit? ___ Yes* ___ No (If yes, date of injury?)_____ Claim #: _____

*If this is a work related visit you will be required to complete Workers' Compensation/Insurance Form (green form)

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING & COMPLETE THE FOLLOWING

If you do not have insurance, how do you plan to pay for your visit today? ___ Cash ___ Credit ___ Check

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- I hereby authorize the payment of medical benefits to Chase City Primary Care for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collection costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize CCPCC to release any medical information necessary to complete and process my insurance claims.

_____ _____

Patient's or Insured's **Signature** (If patient is a Minor, must have Responsible Party Signature) **Date**