

DEPARTMENT USE		OFFICE USE ONLY	
APPOINTMENT DATE	APPOINTMENT TIME	HISTORY NO.	
WITH		REG DATE	
LOCATION		INITIALS	

PLEASE COMPLETE THE FOLLOWING ITEMS AND RETURN IN THE ENCLOSED ADDRESSED ENVELOPE PRIOR TO YOUR APPOINTMENT

**PATIENT INFORMATION – (PLEASE PRINT AND CHECK THE APPROPRIATE BOXES)**

<b>1</b>	HAVE YOU EVER BEEN TO UVA MEDICAL CENTER? <input type="checkbox"/> YES <input type="checkbox"/> NO			<b>2</b>	IF YES, GIVE DATE OF LAST APPOINTMENT		MONTH	DAY	YEAR		
<b>3</b>	NAME	LAST	SUFFIX	MAIDEN NAME	FIRST		MIDDLE INITIAL				
<b>4</b>	MAILING ADDRESS										
<b>5</b>	STREET ADDRESS										
<b>6</b>	CITY						STATE	ZIP			
<b>7</b>	HOME PHONE	AREA CODE			<b>8</b>	BUSINESS PHONE	AREA CODE			EXTENSION	
<b>9</b>	SOCIAL SECURITY NUMBER			<b>10</b>	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>11</b>	DATE OF BIRTH	MONTH	DAY	YEAR
<b>12</b>	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> OTHER										
<b>13</b>	MARITAL STATUS <input type="checkbox"/> S=SINGLE <input type="checkbox"/> M=MARRIED <input type="checkbox"/> D=DIVORCED <input type="checkbox"/> X=SEPARATED <input type="checkbox"/> W=WIDOWED										
<b>14</b>	MOTHER'S MAIDEN NAME			<b>15</b>	PATIENT'S EMPLOYER		OCCUPATION		RETIREMENT DATE		
<b>16</b>	PATIENT'S EMPLOYER ADDRESS		STREET		CITY		STATE	ZIP			
<b>17</b>	NEAREST RELATIVE'S NAME (NOT LIVING IN SAME HOUSEHOLD)										
<b>18</b>	NEAREST RELATIVE ADDRESS		STREET		CITY		STATE	ZIP			
	NEAREST RELATIVE HOME PHONE		AREA CODE		NEAREST RELATIVE WORK PHONE		AREA CODE				
<b>19</b>	NEAREST RELATIVE RELATIONSHIP TO PATIENT		<input type="checkbox"/> FA = FATHER <input type="checkbox"/> MO = MOTHER <input type="checkbox"/> HU = HUSBAND <input type="checkbox"/> WI = WIFE <input type="checkbox"/> DA = DAUGHTER <input type="checkbox"/> SO = SON <input type="checkbox"/> BR = BROTHER <input type="checkbox"/> SI = SISTER <input type="checkbox"/> OT = OTHER								

**GUARANTOR INFORMATION (PERSON TO BILL) – IF SAME AS PATIENT, CHECK SELF ON ITEM 20 AND GO TO ITEM 29**

<b>20</b>	GUARANTOR'S RELATIONSHIP TO PATIENT		<input type="checkbox"/> SE = SELF <input type="checkbox"/> FA = FATHER <input type="checkbox"/> MO = MOTHER <input type="checkbox"/> HU = HUSBAND <input type="checkbox"/> WI = WIFE <input type="checkbox"/> DA = DAUGHTER <input type="checkbox"/> SO = SON <input type="checkbox"/> BR = BROTHER <input type="checkbox"/> SI = SISTER <input type="checkbox"/> OT = OTHER								
	IF OTHER, PLEASE DESCRIBE					GUARANTOR SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					
<b>21</b>	GUARANTOR NAME	LAST	SUFFIX	FIRST			MIDDLE INITIAL				
<b>22</b>	GUARANTOR MAILING ADDRESS						<b>23</b>	GUARANTOR SOCIAL SECURITY NUMBER			
<b>24</b>	GUARANTOR MAILING ADDRESS				CITY		STATE	ZIP CODE			
<b>25</b>	GUARANTOR EMPLOYER NAME										
<b>26</b>	GUARANTOR EMPLOYER ADDRESS				CITY		STATE	ZIP CODE			
<b>27</b>	GUARANTOR EMPLOYER PHONE	AREA CODE			<b>28</b>	SPOUSE'S WORK PHONE	AREA CODE:				
<b>29</b>	SPOUSE'S NAME	LAST	SUFFIX	FIRST			MIDDLE INITIAL				
<b>30</b>	DOES THE PATIENT HAVE HEALTH INSURANCE? <input type="checkbox"/> YES, GO TO LINE 31 <input type="checkbox"/> NO, GO TO LINE 73										

**INSURANCE INFORMATION – POLICY 1**

<b>31</b>	INSURANCE COMPANY NAME										
<b>32</b>	INSURANCE COMPANY ADDRESS	STREET:			CITY	STATE	ZIP CODE				
<b>33</b>	SUBSCRIBER NAME	SUBSCRIBER HOME PHONE		AREA CODE							
<b>34</b>	SUBSCRIBER ADDRESS	STREET:			CITY	STATE	ZIP CODE				
<b>35</b>	SUBSCRIBER SEX:	___ MALE ___ FEMALE		<b>36</b>	SUBSCRIBER SOCIAL SECURITY NUMBER: - -						
<b>37</b>	SUBSCRIBER EMPLOYER NAME	SUBSCRIBER WORK PONE			AREA CODE						
<b>38</b>	SUBSCRIBER EMPLOYER ADDRESS	STREET:			CITY	STATE	ZIP CODE				
<b>39</b>	POLICY INCLUDES MAJOR MEDICAL? ___ YES ___ NO			<b>40</b>	TYPE OF COVERAGE: ___ HOSPITAL ___ PHYSICIAN ___ DENTAL (CHECK ALL THAT APPLY)						
<b>41</b>	GROUP NUMBER OR NAME			<b>42</b>	POLICY OR ID NUMBER:						
<b>43</b>	POLICY EFFECTIVE DATE	MONTH	DAY	YEAR	POLICY EXPIRATION DATE	MONTH	DATE	YEAR			
<b>44</b>	PATIENT'S RELATIONSHIP TO SUBSCRIBER	___ FA = FATHER	___ MO = MOTHER	___ HU = HUSBAND	___ WI = WIFE	___ DA = DAUGHTER	___ SO = SON	___ BR = BROTHER	___ SI = SISTER	___ OT = OTHER	
<b>SUBSCRIBER DATE OF BIRTH</b>		/ /		<b>MEDIGAP POLICY?</b>		___ YES ___ NO		<b>EMPLOYER GROUP PLAN</b>		___ YES ___ NO	

**INSURANCE INFORMATION – POLICY 2**

<b>45</b>	INSURANCE COMPANY NAME										
<b>46</b>	INSURANCE COMPANY ADDRESS	STREET:			CITY	STATE	ZIP CODE				
<b>47</b>	SUBSCRIBER NAME	SUBSCRIBER HOME PHONE		AREA CODE							
<b>48</b>	SUBSCRIBER ADDRESS	STREET:			CITY	STATE	ZIP CODE				
<b>49</b>	SUBSCRIBER SEX:	___ MALE ___ FEMALE		<b>50</b>	SUBSCRIBER SOCIAL SECURITY NUMBER: - -						
<b>51</b>	SUBSCRIBER EMPLOYER NAME	SUBSCRIBER WORK PONE			AREA CODE						
<b>52</b>	SUBSCRIBER EMPLOYER ADDRESS	STREET:			CITY	STATE	ZIP CODE				
<b>53</b>	POLICY INCLUDES MAJOR MEDICAL? ___ YES ___ NO			<b>54</b>	TYPE OF COVERAGE: ___ HOSPITAL ___ PHYSICIAN ___ DENTAL (CHECK ALL THAT APPLY)						
<b>55</b>	GROUP NUMBER OR NAME			<b>56</b>	POLICY OR ID NUMBER:						
<b>57</b>	POLICY EFFECTIVE DATE	MONTH	DAY	YEAR	POLICY EXPIRATION DATE	MONTH	DATE	YEAR			
<b>58</b>	PATIENT'S RELATIONSHIP TO SUBSCRIBER	___ FA = FATHER	___ MO = MOTHER	___ HU = HUSBAND	___ WI = WIFE	___ DA = DAUGHTER	___ SO = SON	___ BR = BROTHER	___ SI = SISTER	___ OT = OTHER	
<b>SUBSCRIBER DATE OF BIRTH</b>		/ /		<b>MEDIGAP POLICY?</b>		___ YES ___ NO		<b>EMPLOYER GROUP PLAN</b>		___ YES ___ NO	

CONTINUE TO NEXT PAGE

**INSURANCE INFORMATION – POLICY 3**

<b>59</b>	INSURANCE COMPANY NAME										
<b>60</b>	INSURANCE COMPANY ADDRESS	STREET:				CITY			STATE	ZIP CODE	
<b>61</b>	SUBSCRIBER NAME	SUBSCRIBER HOME PHONE			AREA CODE						
<b>62</b>	SUBSCRIBER ADDRESS	STREET:				CITY			STATE	ZIP CODE	
<b>63</b>	SUBSCRIBER SEX:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>64</b>	SUBSCRIBER SOCIAL SECURITY NUMBER:					-	-
<b>65</b>	SUBSCRIBER EMPLOYER NAME	SUBSCRIBER WORK PHONE			AREA CODE						
<b>66</b>	SUBSCRIBER EMPLOYER ADDRESS	STREET:				CITY			STATE	ZIP CODE	
<b>67</b>	POLICY INCLUDES MAJOR MEDICAL? <input type="checkbox"/> YES <input type="checkbox"/> NO			<b>68</b>	TYPE OF COVERAGE: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DENTAL (CHECK ALL THAT APPLY)						
<b>69</b>	GROUP NUMBER OR NAME			<b>70</b>	POLICY OR ID NUMBER:						
<b>71</b>	POLICY EFFECTIVE DATE	MONTH	DAY	YEAR	POLICY EXPIRATION DATE	MONTH	DATE	YEAR			
<b>72</b>	PATIENT'S RELATIONSHIP TO SUBSCRIBER	<input type="checkbox"/> FA = FATHER	<input type="checkbox"/> MO = MOTHER	<input type="checkbox"/> HU = HUSBAND	<input type="checkbox"/> WI = WIFE	<input type="checkbox"/> DA = DAUGHTER	<input type="checkbox"/> SO = SON	<input type="checkbox"/> BR = BROTHER	<input type="checkbox"/> SI = SISTER	<input type="checkbox"/> OT = OTHER	
<b>SUBSCRIBER DATE OF BIRTH</b>		/ /		<b>MEDIGAP POLICY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			<b>EMPLOYER GROUP PLAN</b> <input type="checkbox"/> YES <input type="checkbox"/> NO				

**ADDITIONAL INFORMATION**

<b>73</b>	IF ACCIDENT, WAS IT JOB RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			<b>74</b>	PLACE ACCIDENT OCCURRED					
<b>75</b>	DATE OF ACCIDENT	MONTH	DAY	YEAR	<b>76</b>	TIME OF ACCIDENT <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.				
<b>77</b>	ACCIDENT TYPE	<input type="checkbox"/> A= AUTO <input type="checkbox"/> C= AUTO -NO FAULT <input type="checkbox"/> D= AUTO- SUING <input type="checkbox"/> F= OTHER ACCIDENT <input type="checkbox"/> H = CRIME VICTIM								
<b>78</b>	INITIAL TREATMENT DATE FOR THIS ACCIDENT			MONTH	DAY	YEAR				
<b>79</b>	REFERRING PHYSICIAN:									
<b>80</b>	REFERRING PHYSICIAN ADDRESS	STREET:				CITY			STATE	ZIP CODE

THANK YOU FOR TAKING TIME TO COMPLETE THIS FORM