Navdeep Mathur, M.D.
Medical Director
Board Certified Internal Medicine

Mark P. Davis, M.D.
Board Certified Emergency Medicine

Virginia Urgent & Primary Care, LLC

VUPC

Cameron S. Hoffman, FNP-BC
Board Certified – Family Practice

Claudia Holsing
Office Manager

PATIENT INFORMATION

Name _____ Sex: M☐ F☐ Birth Date: __/___/_____ SSN _____
Last Name First Name M. Name

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Married☐ Widowed☐ Single☐ Minor☐

Mobile Phone (_____) _____ Separated☐ Divorced☐ Partner for _____ years☐

Email_____ If minor, Guardian Name _____

Preferred Pharmacy _____ Address _____City _____Zip _____ Phone: (____) _____

Name Primary Care Doctor _____ Phone (____) _____

How did you hear about us?☐ Google Search ☐ Website☐ Employer☐ Friend☐ Road Sign ☐ Other Explain _____

In case of emergency who should be notified _____ Relationship: _____Phone: (____) _____

Reason for Visit Today: _____

If you are here for **Worker's Compensation visit please complete WC section below**

PRIMARY INSURANCE

Patient's Relationship to Guarantor: Self ☐ Spouse☐ Child☐ Other ☐ Explain_____

If different than Self please complete the information below:

Guarantor Name: _____ Guarantor DOB: ___/___/_____ Guarantor SSN:_____
Last Name First Name M. Name

Guarantor Address (If different from patient) _____ City _____ State _____ Zip _____

Insurance Company _____ ID# _____ Group# _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes☐ No☐

Guarantor Name: _____ Guarantor DOB: ___/___/_____ Guarantor SSN:_____
Last Name First Name M. Name

Insurance Company _____ ID# _____ Group# _____

WC SECTION

Name of Employer:_____ Address of Employer: _____

Date of Injury: _____ Name Person Authorizing treatment: _____ AND Phone Number: _____

ASSIGMENT AND RELEASE

I, the undersigned, hereby acknowledge that it is the policy of this office that payment be made at each visit and I am responsible for payment of all services rendered on my behalf. In the event that failure to pay results in referral of my account for collection, I agree to pay collection or attorney fees. If the treating physician is a participan in a HMO, PPO, or IPA of which I am a member, I agree to pay any copayment required by my particular plan. Exception to this policy must be confirmed in advance of service. I authorize payment of medical benefits to the physician or supplier of services rendered. I authorize release of any medical information necessary to process this claim and also certify the information contained herein is correct.

Patient's Signature _____ **Date** _____

Medicare Patients Only:
I request that payment of authorized Medicare Benefits be made on my behalf to VUPC for any services rendered to me. I authorize any holder of medical information about me to give the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature _____ **Date** _____