Danville Regional
MEDICAL CENTER

DATE ____________________
PHYSICIAN ____________________

ADVANCE REGISTRATION

We appreciate your time and effort in completing this form. This will allow us to better and more efficiently serve you. Be sure to print your information below. Also be sure to sign the form at the bottom and have a witness signature in the appropriate space.

Patient's Last Name	**First**	**Middle**	**Last Admission Date**
			Check One: Own ☐ Rent ☐
Street Address	**City/State**	**Zip Code**	
Home Phone/Work Phone	**Date of Birth**	**Age**	**Social Security Number**
Patient's Employer	**Employer's Address**	**Occupation**	**Length of Service**

Marital Status (circle): M S D Separated

Next of Kin	**Relationship**	**Address**	**Home/Work Phone**
Employed By	**Employer's Address**	**Occupation**	**Length of Service**

Guarantor Information

(Person Responsible for Payment of Account)

Male ☐
Female ☐

Last Name	**First**	**Middle**	**Social Security #**	**Date of Birth**
Telephone#	**Street Address**	**City/State/Zip**		**Relationship**
Employed By	**Employer's Street Address**	**City/State/Zip**		**Occupation**

Insurance Information

(Please Bring Insurance Cards When Admitted)

Insurance Company	**Policy #**	**Group #**	**Name of Policy Holder**
Medicaid 12 Digit #	**Name on Card**	**Begin Date**	**End Date**

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS – (EXPIRES AFTER 12 MONTHS): I consent to the release from my medical records of such information as may be required by my insurance carrier or government agency for the processing of my claims for hospital, physician's and medical benefits. I authorize the mentioned insurance company to remit to Danville Regional Medical Center any hospital benefits, including major medical otherwise payable to me.

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING: A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to bodily fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such 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 (except in an emergency situation) for HIV antibodies pursuant to this provision, the testing would be explained and you would be given opportunity to ask any questions you might have. I have read and understand the above "Notice of Deemed Consent to HIV blood testing".

SIGNATURE ______________________ DATE ______________ WITNESS ____________________
(Patient or Parent/Guardian if Minor)