

ARTHRITIS CONSULTANTS OF TIDEWATER
RHEUMATOLOGY o OSTEOPOROSIS o INTERNAL MEDICINE
Phone (757) 491-7359 o FAX (757) 491-9359

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PATIENT INFORMATION

Patient Name: _____

Street Address: _____

City: State: Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Social Security Number: _____

Date of Birth: _____ Sex: (please check one box) Male Female

Marital Status: (please check one box) Married Single Divorced Widowed

Email: _____

Primary Language: _____ Race: _____

Primary Care Physician Name: _____ Phone Number (____) _____

Referring Provider Name: _____ Phone Number (____) _____

OCCUPATION INFORMATION

Employer: _____ Occupation: _____

Street Address: _____

City: State: Zip Code: _____

EMERGENCY INFORMATION (Next of Kin)

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____

Pharmacy: _____ Phone Number: (____) _____

City: _____ State _____

INSURANCE INFORMATION

Primary Insurance Name: _____

ID Number: _____ Group Number: _____

Name of Insured: _____ Relationship to Insured: _____

Insured SSN: _____ Insured Date of Birth: _____

Secondary Insurance Name: _____

ID Number: _____ Group Number: _____

Name of Insured: _____ Relationship to Insured: _____

Insured SSN: _____ Insured Date of Birth: _____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the filing of any insurance in force and the direct payment to Arthritis Consultants of Tidewater of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Arthritis Consultants of Tidewater for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Arthritis Consultants of Tidewater. In consideration of service rendered, the undersigned patient, spouse, and/or responsible party agree that each will be jointly and severally liable and guarantee payment for any or all services rendered. The undersigned agrees to pay , in addition to the accrued charges, All the costs of collecting the amount due, Including Attorneys fees.

Patient Signature: _____ **Date Signed:** _____

933 First Colonial Road
Suite 100
Virginia Beach, VA 23454

700 N. Battlefield Blvd.
Suite A
Chesapeake, VA 23320

9524 Hospital Avenue
Nassawadox, VA 23413

102 Fairview Drive
Suite E
Franklin, VA 23851