LOUDOUN COMMUNITY
MIDWIVES

19465 Deerfield Avenue, Suite 205
Leesburg, Virginia 20176
(703) 726-1300

DEMOGRAPHIC UPDATE

PATIENT

LAST NAME	FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH
SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN	EMAIL ADDRESS (To view your patient records online and receive reminders of appointments)		
STATUS *(please circle one)* Single Married Divorced Widow Partner Legally Separated			STUDENT *(please circle one)* No Part Time Full Time	
STREET ADDRESS	CITY/STATE			ZIP CODE
HOME PHONE *(include area code)*	CELL PHONE		WORK PHONE	

INSURANCE – POLICY HOLDER's Information

1. PRIMARY INSURANCE	POLICY ID NUMBER		GROUP ID #	EFFECTIVE DATE
NAME OF POLICY HOLDER (First, MI, Last)	DATE OF BIRTH (Policy Holder)	PHONE # (Policy Holder)	MAILING ADDRESS (Policy Holder)	
2. SECONDARY INSURANCE	POLICY ID NUMBER		GROUP ID #	EFFECTIVE DATE
NAME OF POLICY HOLDER (First, MI, Last)	DATE OF BIRTH (Policy Holder)	PHONE # (Policy Holder)	MAILING ADDRESS (Policy Holder)	

EMERGENCY CONTACT

NAME (First, MI, Last)	ADDRESS (Street, City, State, ZIP)	PHONE	Relationship to Patient

CONSENT FOR COMMUNICATION

I GIVE PERMISSION to Loudoun Community Midwives to speak with the person(s) listed below regarding my medical care. Please be advised, we cannot give information to anyone without your written consent.

1. AUTHORIZED PERSON	Relationship to Patient	Phone Number
2. AUTHORIZED PERSON	Relationship to Patient	Phone Number

I AUTHORIZE Loudoun Community Midwives to leave a detailed voicemail message at the following number(s):
Messages may at times include some protected health information, including appointment reminders, test results and instructions. I understand that with my signature I am authorizing the release of oral communication by Loudoun Community Midwives to the following numbers:

HOME PHONE	CELL PHONE	WORK PHONE

SIGNATURE OF PATIENT, PARENT/LEGAL GUARDIAN	PLEASE PRINT NAME	RELATIONSHIP TO PATIENT (if signature is not of patient)	**DATE**