LOUDOUN
RHEUMATOLOGY
CENTER
Healthy Joints · Healthy Bones

PATIENT REGISTRATION FORM

DATE____________________

PATIENT NAME________________________________ DATE OF BIRTH_______________

SEX______M_____F MARITAL STATUS___M____S______D____

ADDRESS____

____ EMAIL ADDRESS____________________

PHONE (HOME) _______________ (WORK) ______________ (CELL) ____________________

EMPLOYER________________________________OCCUPATION____________________

EMPLOYER/ADDRESS____

CITY/STATE/ZIP____________________________

REFERRING PHYSICIAN______________________________PHONE NO.______________

REFERRING PHYSICIAN ADDRESS____

LEGAL GUARDIAN/PARENT/SPOUSE'S NAME____________________________________

SPOUSE'S EMPLOYER _____________________BUSINESS PHONE__________________

EMERGENCY CONTACT____________________RELATIONSHIP_____________________

PHONE NUMBER ________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME_______________________________________

POLICY/ID#: ______________________GROUP #__________________________________

POLICY HOLDER NAME: ____

RELATIONSHIP TO PATIENT____

BIRTHDATE OF POLICY HOLDER____

SECONDARY INSURANCE COMPANY NAME_____________________________________

ID #______________ GROUP#____

POLICY HOLDER NAME_____________________RELATIONSHIP TO PATIENT___________

BIRTHDATE OF POLICY HOLDER ____

AUTHORIZATION:

I herby authorize Loudoun Rheumatology Center to release any information requested with respect to insurance claims and bills as the provider of the service rendered. I also authorize payment of insurance benefits directly to Loudoun Rheumatology Center.

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Date Signature of Patient/Parent/Guardian