



Patient Registration Form

Date _____

Name _____ Date of Birth _____ Sex _____

Address _____

_____ Email Address _____

Phone (Home) _____ (Work) _____ (Cell) _____

Employer/Address _____ Soc. Sec. # _____

Referring Physician _____

Primary Care Physician _____

Pharmacy/Phone _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Name of Spouse and work number _____

Number of children _____ Emergency Contact: _____

Phone Number _____

Chief

Complaint: _____

Medications/Dosage

PRESENT _____

The Past

Year _____

Are you **allergic** to or intolerant of any drugs? If yes, please list the drug(s) and your reaction. _____

Past

operations/dates _____

Other Major Illnesses &

Hospitalizations _____

Do you smoke? _____ Packs/Day _____ Did you smoke? _____ Date Stopped? _____

How often do you have a drink? (Beer, Wine, Liquor)? _____

Have you ever had a problem related to alcohol? _____

Please circle if there is any family history of: Gout? Alcoholism?

Asthma? Stroke? Arthritis? Cancer? Heart Disease?

Diabetes? Kidney Disease? High Blood Pressure? Mental Illness?

Osteoporosis? Lupus? Scleroderma? Tuberculosis?



LOUDOUN
RHEUMATOLOGY
C E N T E R
Healthy Joints . Healthy Bones

Primary Insurance Company/Address/Phone _____

Name of Policy Holder (If other than patient) _____ Birthdate of Policy holder _____ Relationship to patient _____

ID # _____ Group # _____

Additional Insurance Company/Address/Phone _____

Name of Policy Holder (if other than patient) _____ Birthdate of Policy holder _____ Relationship to patient _____

ID # _____ Group# _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to Dr. _____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Dr. _____ to release any medical or incidental information that may be necessary in order to carry out the treatment, payment, or health care operations of Loudoun Rheumatology Center, PC.

MEDICARE/MEDICAID:

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient (Please print) _____

Signature _____ Date _____

Parent/Guardian (Please Print) _____

Signature _____ Date _____

Additions/Changes/Comments _____
