

FALLS CHURCH MEDICAL CENTER

6060 Arlington Boulevard • Falls Church, Virginia 22044 • (703) 533-2222

PATIENT REGISTRATION *Please Print Clearly*

PATIENT NAME: <small>First</small> _____ <small>Middle</small> _____ <small>Last</small> _____				DATE OF BIRTH	
HOME ADDRESS: <small>Street</small> _____		APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO.			MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M	SEX	HOME PHONE ()
EMPLOYER _____				<input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student: FT <input type="checkbox"/> PT <input type="checkbox"/>	
PRIMARY CARE PHYSICIAN _____			REFERRING PHYSICIAN _____		
WORK PHONE ()					

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME		LAST NAME		RELATIONSHIP TO PATIENT
	HOME ADDRESS			CITY	STATE & ZIP CODE
	EMPLOYER			WORK PHONE ()	HOME PHONE ()
PRIMARY INSURANCE	INSURANCE COMPANY NAME			ID OR POLICY NO.	GROUP/CODE
	SUBSCRIBER'S NAME		SSN	SEX	HOME PHONE ()
	SUBSCRIBER'S ADDRESS			WORK PHONE ()	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME			ID OR POLICY NO.	GROUP/CODE
	SUBSCRIBER'S NAME		SSN	SEX	HOME PHONE ()
	SUBSCRIBER'S ADDRESS			WORK PHONE ()	SUBSCRIBER'S DATE OF BIRTH

PATIENT AUTHORIZATION

I, the undersigned patient/responsible party, agree to pay for all services rendered for the above patient by the doctors and staff of the Falls Church Medical Center, Inc., including physician, dentist, nursing, laboratory, and/or radiology services, except where, by direct contract between the Falls Church Medical Center, Inc. and my insurance company, the patient/responsible party is only responsible to pay for non-covered services and/or co-payments, in which case I, the undersigned patient/responsible party, agrees to pay for such non-covered services deductibles, or co-payments. This agreement is entered into in the County of Fairfax, Virginia on _____.

(Date)

I hereby authorize Falls Church Medical Center to file insurance claims to my carrier on my behalf and the release of any medical information necessary to process the claim(s).

PLEASE PRINT Patient/Responsible Party Name _____

SIGNATURE of Patient/Responsible Party _____

FOR OFFICE USE ONLY,

DR. NO.: _____

ACCOUNT NO.: _____

PREPARED BY: _____