FAIRFAX Allergy ASTHMA & SINUS CLINIC

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ADULT PATIENT REGISTRATION

Please initial after each of the following if we may leave messages regarding your care:
Work _____ Home _____ Cell _____ E-mail _____

☐ New Patient
☐ Existing/Update

PLEASE PRINT – FILL ALL AREAS

PATIENT INFORMATION

PATIENT'S FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	HOME PHONE NUMBER
HOME ADDRESS		CITY, STATE & ZIP	CELL PHONE NUMBER
EMAIL			WORK PHONE NUMBER
EMPLOYER NAME & ADDRESS			
PCP/REFERRING PHYSICIAN			PCP/REFERRING PHYSICIAN PHONE NUMBER

HOW DID YOU HEAR ABOUT OUR PRACTICE?
☐ FRIEND/RELATIVE ☐ AD/NEWSPAPER ☐ INTERNET ☐ PHYSICIAN

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	CONTACT NUMBER

INSURANCE INFORMATION *Insurance info and copy of insurance cards needed to filed for benefits*

POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER OF SUBSCRIBER	POLICY HOLDER'S BIRTH DATE	POLICY HOLDER'S SEX ☐ MALE ☐ FEMALE
POLICY HOLDER'S RELATIONSHIP TO PATIENT IS: ☐ SELF ☐ PATIENT ☐ SPOUSE ☐ OTHER		POLICY HOLDER'S EMPLOYER	
PRIMARY INSURANCE COMPANY	CO-PAYMENT/CO-INSURANCE AMOUNT	IDENTIFICATION/POLICY NUMBER	GROUP NUMBER
INSURANCE ADDRESS	CITY	STATE/ZIP	EFFECTIVE DATE

DOES YOUR INSURANCE REQUIRE YOU TO HAVE A REFERRAL TO SEE A SPECIALIST? ☐ YES ☐ NO

I certify that the information I have reported above is correct and that as the Parent/Guardian/Guarantor. I acknowledge receipt of the Notice of Privacy Practices given to me by **FAASC**.

****PAYMENT IS DUE AT TIME OF SERVICE****

Read and Sign Conditions of Registration on the Back of this Form

SIGNATURE OF PATIENT/GUARDIAN/GUARANTOR PRINT NAME DATE

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