



# Alexandria Fairfax Neurology, PC

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 Phone: (703) 845-1500 Fax: (703) 845-1300

8505 Arlington Boulevard, Suite 450, Fairfax, Virginia 22031  
 Phone: (703) 280-1234 Fax: (703) 280-1235

**OFFICE USE ONLY**  
 New Patient  
 Current Patient Update  
 Workers' Comp

## ADULT PATIENT REGISTRATION

					DATE				
PATIENT NAME - LAST			FIRST		INITIAL		NICKNAME (IF ANY)		
HOME ADDRESS-STREET				SOCIAL SECURITY NUMBER		BIRTHDATE (MO/DA/YR)		AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
CITY		STATE	ZIPCODE	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		HOME TELEPHONE			
EMERGENCY CONTACT:			RELATIONSHIP		HOME PHONE		WORK PHONE		
ALLERGIES (PLEASE LIST ALL KNOWN)									
<b>EMPLOYMENT INFORMATION</b>									
EMPLOYER				OCCUPATION					
EMPLOYER ADDRESS (STREET, CITY, STATE, ZIPCODE)						WORK TELEPHONE			
<b>INSURANCE INFORMATION</b>									
NAME OF FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT THAN PATIENT)					CARDHOLDER SS#		CARDHOLDER BIRTHDATE		
ADDRESS (STREET, CITY, STATE, ZIPCODE)					HOME TELEPHONE		WORK TELEPHONE		
PRIMARY HEALTH INSURANCE CO. NAME			POLICYHOLDER NAME		RELATIONSHIP TO PATIENT		CIRCLE PLAN TYPE HMO PPO NEITHER		
INSURANCE CO. ADDRESS			ID/POLICY NUMBER		GROUP NUMBER		EFFECTIVE DATE		
SECONDARY HEALTH INSURANCE CO. NAME			POLICYHOLDER NAME		RELATIONSHIP TO PATIENT		CIRCLE PLAN TYPE HMO PPO NEITHER		
INSURANCE CO. ADDRESS			ID/POLICY NUMBER		GROUP NUMBER		EFFECTIVE DATE		
<b>REFERRAL INFORMATION</b>									
FAMILY PHYSICIAN		REFERRED BY		ADDRESS			TELEPHONE		
ANY MEMBER OF FAMILY TREATED BY OUR GROUP BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS YOUR CURRENT PROBLEM		WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>IF DUE TO A WORK RELATED INJURY, FILL OUT THE SECTION BELOW</b>									
DATE OF INJURY		WAS INJURY REPORTED TO SUPERVISOR? <input type="checkbox"/> YES <input type="checkbox"/> NO			NAME OF SUPERVISOR				
EMPLOYER AT TIME OF INJURY		EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIPCODE)					TELEPHONE		
DESCRIPTION OF INJURY									
WORKERS' COMPENSATION INSURANCE CARRIER						CLAIM NUMBER			
WORKERS' COMPENSATION INSURANCE CARRIER ADDRESS (STREET, CITY, STATE, ZIPCODE)						TELEPHONE			
IS AN ATTORNEY ASSISTING YOU WITH THIS WORKERS' COMPENSATION CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO									
ATTORNEY'S NAME		ATTORNEY'S ADDRESS (STREET, CITY, STATE, ZIPCODE)					TELEPHONE		

**PLEASE TURN THIS FORM OVER AND COMPLETE THE REVERSE SIDE.**

**PATIENT NAME** \_\_\_\_\_

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**Authorization for Assignment of Benefits & Release Information**

I authorize Alexandria Fairfax Neurology, PC to apply for benefits from \_\_\_\_\_  
\_\_\_\_\_ (insurance carrier) and further authorize payment directly to  
Alexandria Fairfax Neurology, PC of the surgical and/or medical and/or mental health benefits, if any,  
otherwise payable to me for services rendered by Alexandria Fairfax Neurology, PC

I further authorize the release of medical information required by my insurance carrier or its  
designated review agent, or (if applicable) my employer's workers' compensation insurance carrier in  
order to determine benefits to which I may be entitled, or to designated agents of Alexandria Fairfax  
Neurology, PC. I permit a copy of this authorization to be used in place of the original. This  
authorization may be revoked either by me or by the above carrier at any time in writing.

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_____ Name of Policyholder, Patient or Parent/Guardian	_____ Signature of Policyholder, Patient or Parent/Guardian	_____ Date
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**FINANCIAL AGREEMENT**

I hereby assume financial responsibility for and agree to make payment in full to Alexandria Fairfax  
Neurology, PC for all charges for service or medical supplies furnished for the above-named patient not  
otherwise authorized or paid by my insurance carrier. Payment is to be made within thirty (30) days  
as statements are presented with settlement in full, or payment arrangements are to be made with the  
Patient Accounts Department. I certify that the financial information given is true, accurate and  
complete to the best of my knowledge, and further authorize Alexandria Fairfax Neurology, PC to  
investigate any and all financial information given concerning this or related claims.

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_____ Name of Policyholder, Patient or Parent/Guardian	_____ Signature of Policyholder, Patient or Parent/Guardian	_____ Date
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