

FAIRFAX FAMILY PRACTICE PATIENT REGISTRATION

PATIENT INFORMATION	
Name: _____	Date of Birth: ____/____/____ Age: ____ Sex ____
SSN: _____	Home Phone: (____) _____
Cell Phone: (____) _____	E-mail: _____
Address: _____	Nick Name: _____
City: _____	State: _____ Zip Code: _____
Employer: _____	Work Phone : (____) _____
Employer Address: _____	Date of Employment: _____
Physician: _____	How did you find out about us? _____
INSURANCE INFORMATION	
-PRIMARY INSURANCE INFORMATION	
Subscriber Name: _____	Policy #: _____ Group # _____
Subscriber DOB: _____	Subscriber SSN: _____
EMERGENCY CONTACT INFORMATION	
Name: _____	Relation to Patient: _____
Home Phone: (____) _____	Work Phone : (____) _____
- SECONDARY INSURANCE INFORMATION	
Subscriber Name: _____	Policy #: _____ Group # _____
Subscriber DOB: _____	Subscriber SSN: _____
Relation to Patient: _____	
Subscriber Employer: _____	Insurance Co. Name: _____

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to FFPC, PC, or any of its affiliates or agents, lenders, or any third party services acting for FFPC, PC, or any of its affiliates.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to FFPC and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time. I authorize FFPC to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician for services.

Signed: _____ Date: _____