ASTHMA & PULMONARY SPECIALISTS OF NORTHERN VIRGINIA, LTD.

MASTER REGISTRATION

DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ HOME PHONE (___)_____
PLEASE PRINT LAST FIRST MI

ADDRESS: _____WORK PHONE (___)_____

CITY: _____ST: ____ ZIP: _____ CELL PHONE (___)_____

DATE OF BIRTH: ____/_____/_____ SEX: ___MALE __ FEMALE MARITAL STATUS _____

PATIENTS SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

INSURANCE INFORMATION
**** PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO BE COPIED ****

PRIMARY INSURANCE: _____

INSURANCE ADDRESS: _____

POLICY/IDENTIFICATION NUMBER: _____

GROUP ID # _____ POLICY HOLDER: _____

POLICY HOLDER'S DATE OF BIRTH: ___/____/____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

INSURANCE ADDRESS: _____

POLICY/IDENTIFICATION NUMBER: _____

GROUP ID # _____ POLICY HOLDER: _____

POLICY HOLDER'S DATE OF BIRTH: ___/____/____ RELATIONSHIP TO PATIENT: _____

CONCERNING INSURANCE

I HEREBY AUTHORIZE THIS PHYSICIAN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER, (OR, IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINI- STRATION AND HEALTH CARE FINANCING ADMINISTRATION) A COPY OF THIS AUTHORZAITON MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME IN WRITING.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO THIS PHYSICIAN FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINIAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

X_____ _____

SIGNATURE OF PATIENT, INSURED, OR BENEFICIARY DATE