OLD DOMINION MEDICAL CENTER

6715 Whittier Avenue, Mclean, Va 22101

REGISTRATION FORM

Chart # _____

PATIENT INFORMATION

1

First Name:	M.I.	Last Name:	Social Security #:

Street Address:	City:	State:	Zip Code:

Home Phone #:	Date Of Birth: (MM/DD/YY)	Sex: (Please circle only one) Male / Female	Marital Status (Please circle only one): Single / Married / Divorced / Separated / Widowed

Employer:	Employer Address:	City:	State:	Zip Code:

Occupation:	Work Phone #:	Work Status (Please circle only one) Full Time / Part Time / Retired	Email Address

GUARANTOR INFORMATION (The Responsible Party)

2

First Name:	M.I.	Last Name:	Social Security #:

Street Address (If different from address above)	City:	State:	Zip Code:

Home Phone #:	Work Phone #:	Fax #:	Relationship to Patient

Emergency Contact First Name:	Emergency Contact Last Name:	Emergency Contact Phone #:	Emergency Contact Email:

PAYMENT & INSURANCE INFORMATION (Please provide us with a copy of your Insurance Card)

3

Primary Insurance:	Type: Individual / Group / Medicaid / Medicare / Other	Co-Payment: $

Policy Number:	Group Plan Number:	Patient's relationship to Subscriber: (Please circle only one) Self / Spouse / Child / Parent / Other

Primary Insurance:	Type: Individual / Group / Medicaid / Medicare / Other	Co-Payment: $

Policy Number:	Group Plan Number:	Patient's relationship to Subscriber: (Please circle only one) Self / Spouse / Child / Parent / Other

Old Dominion Assignment of Benefits, Release of Information, Payment Agreement, HIPAA Guidelines

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Old Dominion Medical Center will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Old Dominion Medical Center.

I permit Old Dominion Medical Center to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act of 1996).

I agree that I am responsible for full payment of this account and any court costs and attorney fees associated with the collection of this account.

_____ _____

Responsible Party Date

_____ _____

Patient Date

Allen B. Horne, MD Fredrick W. Hubach, MD Ritu B. Cuttica, DO Patricia Leighton, NP