



**MEDICAL ASSOCIATES
OF ARLINGTON**

REGISTRATION FORM

PATIENT INFORMATION						
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Last Name	First	Middle		
Legal Name (if different from above)		Maiden Name or Aliases	Date of Birth / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Language:		Race:	Ethnicity:			
Email:						
Street Address			Social Security Number		Home Phone # ()	
City	State	Zip Code	P.O. Box		Cell Phone # ()	
Occupation		Employer			Work Phone # ()	
I selected/found this practice thru (please check one box):						
<input type="checkbox"/> Advertisement <input type="checkbox"/> Virginia Hospital Center <input type="checkbox"/> Internet Search <input type="checkbox"/> Insurance Website <input type="checkbox"/> Family/Friend <input type="checkbox"/> Yellow Pages						
<input type="checkbox"/> Physician _____			<input type="checkbox"/> Other _____			
Pharmacy Name	Address	Zip Code	Phone # ()		Fax # ()	
INSURANCE INFORMATION						
(Please present your insurance card to the receptionist)						
Person Responsible for Bill		Date of Birth / /	Address (if different):			Home Phone # ()
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation		Employer	Employer's Address			Work Phone # ()
Primary Insurance Carrier:						
Subscriber's Name	Subscriber's SSN	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Date of Birth / /	Group #	Policy #
Co-Pay \$						
Secondary Insurance Carrier:						
Subscriber's Name	Subscriber's SSN	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Date of Birth / /	Group #	Policy #
Co-Pay \$						
IN CASE OF EMERGENCY						
Name of Emergency Contact (not living at same address)			Relationship to Patient	Home Phone # ()		Work Phone # ()
<i>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Medical Associates of Arlington or insurance company to release any information required to process my claims.</i>						
Patient Signature				Date		