Patient Registration Form

Date**:** _____

Billing Information

Person Responsible for Bill: _____ Relationship: _____

Contact Phone#: _____

Patient Information

Patient's Last Name: _____ First: _____ Middle: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different from mailing): _____

City: _____ State: _____ Zip: _____

Home Phone# _____ Work Phone# _____ Cell Phone# _____

Email Address: _____

Male ☐ Female ☐ Patient Social Security #: _____ Patient Date of Birth: _____

Patient Employer: _____ Occupation: _____

Marital Status S_____ M _____ D _____W _____ Spouse Name: _____

Emergency Contact

Emergency Contact: _____ Relationship _____ Phone #: _____

Preferred Method of Communication (Please Circle): **Cell** **Home** **Patient Portal**

Insurance Information

Primary Insurance: _____ Policyholder: _____ Relationship: _____

Policyholder SSN: _____ Policyholder DOB: _____

Employer of Policyholder: _____

Member ID#: _____ Group#: _____

Secondary Insurance: _____ Policyholder: _____ Relationship: _____

Policyholder SSN: _____ Policyholder DOB: _____

Employer of Policyholder: _____

Member ID#: _____ Group#: _____

Workers' Compensation: provide claim information to front office staff

How did you hear about us? (Please circle one)

- PCP/Referring provider/Insurance
- Previous/Existing patient
- Coworker/Friend/Family
- Magazine/Newspaper
- Radio/Billboard
- Social Media/Website
- Community Event
- Hospital (please circle)
  - Fauquier
  - Novant Health UVA
  - Culpeper
  - Other