

Reston Surgical Associates

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PATIENT REGISTRATION

PATIENT NAME: FIRST			M.I.	LAST	DATE OF BIRTH	SOCIAL SECURITY #	Male / Female? M or F
HOME ADDRESS				APT #	CITY	STATE	ZIP
EMPLOYER						ADDRESS	
OCCUPATION						WORK PHONE	
REFERRED BY: FIRST and LAST NAME				CELL PHONE			
ALLERGIES TO MEDICATIONS		PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known)				MARITAL STATUS ___S ___M ___W ___D	
SPOUSES NAME				WORK PHONE:		OCCUPATION	
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)						TELEPHONE	
POLICY HOLDER NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH		FINANCIALLY RESPONSIBLE PERSON ___PATIENT ___SPOUSE ___PARENT ___OTHER	
EMPLOYER						ADDRESS	
						WORK PHONE	

Primary Insurance Billing Information

Secondary Insurance Billing Information

Ins. Co. Name _____ Address: _____ City, State & Zip: _____ ID.No: _____ Group Name: _____ Group # _____ Subscriber: _____ (Person's Name) Subscribers Date of Birth: _____ Subscriber's Social Security # _____	Ins.Co. Name _____ Address: _____ City, State & Zip: _____ ID.No: _____ Group Name: _____ Group# _____ Subscriber: _____ (Person's Name) Subscriber's Date of Birth: _____ Subscriber's Social Security # _____
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PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during collection process

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize DGT, MD, FACS, PLLC to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance:

I understand that I will be responsible for a \$10.00 processing fee if I do not pay my copay at the time of my visit. I certify that the information I provided above is correct.

Date

Signature of Subscriber or Beneficiary

I acknowledge that I have been offered a copy of the privacy notice of Reston Surgical Associates.

Copy Taken _____ Copy Declined _____

Date

Signature of Patient