CAPITAL AREA INTERNAL MEDICINE

Sree L. Gogineni, MD & Lauren Naughton, MS, PA-C

Ph: (703)255-6010 Fax: (703)255-6011

2235 Cedar Ln #302
Vienna, VA 22182

44121 Harry Byrd Hwy #250
Ashburn, VA 20147

2010 B Opitz Blvd
Woodbridge, VA 20191

PATIENT REGISTRATION FORM

□ **New** □ **Changes/Updates**

PERSONAL INFORMATION

Patient's Last Name: _____Middle: _____First: _____

SSN#: _____DOB: _____/_____/_____Age: _____ Sex: ☐ F ☐ M Marital Status: ☐M ☐S ☐W ☐D

Race: _____Ethnicity: (Check one) ☐ Hispanic ☐ Non-Hispanic ☐ Asian ☐ Black ☐ Caucasian ☐ Other

Home Address: _____City: _____Zip: _____

Home Telephone: _____Work Telephone: _____Cell: _____

Local Pharmacy Name: _____Telephone: _____

Pharmacy Address: _____City: _____State: _____Zip: _____

Patient Email: _____Preferred way of communication: _____

Emergency Contact Name: _____Relationship: _____Telephone: _____

Employer: _____Occupation: _____

Employment Address: _____City: _____State: _____Zip: _____

BILLING AND INSURANCE INFORMATION - We will request to scan your ID and insurance card

1. Primary Insurance: _____Policy #: _____Group #: _____

Policy Holder's Address: _____City: _____State: _____Zip: _____

Policy Holder's Name: _____DOB: _____/_____/_____SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____

2. Secondary Insurance: _____Policy #: _____Group #: _____

Policy Holder's Address: _____City: _____State: _____Zip: _____

Policy Holder's Name: _____DOB: _____/_____/_____SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____

3. Tertiary Insurance: _____Policy #: _____Group #: _____

Policy Holder's Address: _____City: _____State: _____Zip: _____

Policy Holder's Name: _____DOB: _____/_____/_____SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____

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HOW DID YOU HEAR ABOUT US?

Whom can we thank for the referral?

☐Physician ☐Insurance ☐Company ☐Family ☐Friend ☐ Internet ☐ Other: Name:_____

WORKMAN'S COMPENSATION AND AUTO ACCIDENT RELATED INFORMATION

Worker's Comp Name:_____Auto Insurance Company:_____

Date of Accident: _____Where:_____

Claim or File No._____Adjuster/Contact person name:_____

Adjuster/Contact person telephone:_____

ADVANCED MEDICAL DIRECTIVE

Do you have one? ☐ Yes ☐No

If so, please provide our office with a copy for your records.
If not, please ask our office for more information.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Capital Area Internal Medicine Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Capital Area Internal Medicine, Inc. and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

_____ _____ _____

Signature Patient/Policy Holder Date

Responsible Person if Patient is a Minor: _____