

Ashburn Family Healthcare, PLLC

Patient Registration Form

Thank you for choosing Ashburn Family Healthcare to take care of your primary health care needs. Please completely fill out this form to ensure timely healthcare service.

How did you hear about us? _____

PATIENT INFORMATION:

Full Name _____ Date of Birth _____ SSN _____
 Sex _____ Marital Status _____ Race _____ Ethnicity _____
 Address _____ Home Phone _____
 _____ Work Phone _____
 Email _____ Cell Phone _____
 Occupation _____ Employer _____
 Emergency Contact (Name/Phone Number/Relationship) _____

INSURANCE INFORMATION:

Primary Insurance Plan _____ Policy Number _____
 Group Number _____ Phone Number _____
 Secondary Insurance Plan _____ Policy Number _____
 Group Number _____ Phone Number _____

INSURANCE SUBSCRIBER'S INFORMATION:

If you are covered under the policy of a partner, parent, or legal guardian, please tell us about them:

Full Name _____ Date of Birth _____ SSN _____
 Relationship to Patient _____ Employer's Name _____
 Address if different from above _____ Cell Phone _____
 _____ Work Phone _____

I hereby assign to Ashburn Family Healthcare any insurance or other third-party benefits available for health care services provided to me. I understand that Ashburn Family Healthcare has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Ashburn Family Healthcare, I agree to forward to Ashburn Family Healthcare all insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

I hereby consent to the release and re-disclosure of my medical records to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to Ashburn Family Healthcare or any of its affiliates or agents, lenders, or any third party services acting for Ashburn Family Healthcare or any of its affiliates.

Signature of Patient or Legal Guardian

Relationship to Patient

Date