INOVA™

1PAND

**Patient Information:**

Name (last, first, middle initial): _____ Phone Number (home): _____

Email Address: _____ Alternate Phone Number: _____ ☐ cell ☐ work

Address: _____ Apt # _____ City _____ State ____ Zip Code _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Social Security Number: _____

Employer: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student ☐ Other _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

**Demographics:**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ More than one race ☐ Declined ☐ Hispanic ☐ Other _____

Ethnicity: ☐ American ☐ Asian Indian ☐ Caribbean Islander ☐ Chinese ☐ Eastern European ☐ Filipino ☐ Japanese ☐ Korean ☐ Middle Eastern ☐ North African ☐ Pakistani ☐ Vietnamese ☐ West African ☐ Declined ☐ Other _____

**Insurance Information:**

Primary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

**Insured Information (if other than patient): We will request to scan your ID and insurance card.**

Subscriber/Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Date of Birth: _____ Subscriber Employer: _____

Inova Medical Group reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee Schedule: New Patient - $50.00; Established Patient - $35.00

Patient/Parent/Guardian Signature: _____ Date: _____ Time: _____

**Specialty Care Only:** Please indicate your referring doctor as well as other doctors who will need information about your treatment.

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

Referring MD Name: _____ Specialty: _____

Address: _____ Phone number: _____ Fax Number: _____

PATIENT IDENTIFICATION

**Inova Medical Group**

# Patient Registration Form

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