Arjun Medical Center, PC
7350 Heritage Village Plaza, Suite 101
Gainesville, VA 20155
P: (571) 248-6666 F:(571) 248-6667

Registration Form

Date: **Patient Information** Home Phone:

Name: Email:

Last Name First Name Initial

Address: City: State: Zip:

Sex: M F Age: Birth Date: Single Married Widowed Seperated Divorced

Patients Employer: Occupation:

Business Address: Work Phone:

Whom may we thank to refering you?

In Case of emergency who should be notified? Phone:

Primary Insurance

Person Responsible for Account:

Last Name First Name Initial

Relationship to Patient: Birth Date:

Address: City: State: Zip:

Person Resonsible Employed By: Occupation:

Business Address: Work Phone:

Insurance Co: Group #: Member #:

Additional Insurance

Is patient Covered by additional insurance? Yes No Subscriber Name:

Relationship to Patient: Birth Date:

Address: City: State: Zip:

(if different than Patient)

Subscriber Employed By: Work Phone:

Insurance Co: Group #: Member #:

Assignment and Release

I, the undersigned certify that I (or my department) have insurance coverage with

name of insurance company(ies)

and assign directly to Arjun Medical Center, PC all insurance benefits, If any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I here by authorize Arjun Medical Center,PC to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.

Responsible Party Signature **Relationship** **Date**