- LEESBURG -
MEDICAL CLINIC

Registration Form

Part I - Patient Profile	How did you hear about us?		
Last Name (in CAPs)		Gender: M☐ F☐	E-mail Address
First Name (in CAPs)		Date of Birth of Patient (MM/DD/YYYY)	
Mailing Address (Street Number and Name, appt #)		SSN of Patient	
City	State / Zip Code	Employer of Patient	Occupations
Evening Phone number ---------- ---------- ---------- Daytime Phone Number ---------- ---------- ----------		Insurance Policy Holder/Name on Card Relationship to Patient	

Emergency Contact Information

Name of Spouse	Employer of Spouse	Contact Phone Number
Drug allergies		

Part II – Insurance Company(s) Profile

Name of Primary Insurance Company and Address			
Effective Date	Policy or ID Number	Group Number	Phone Number
Name of Policy Holder/Name on Insurance Card		Date of Birth of Policy Holder (MM/DD/YYYY)	
Name of Secondary Insurance Company and Address			
Effective Date	Policy or ID Number	Group Number	Phone Number
Name of Policy Holder/Name on Insurance Card		Date of Birth of Policy Holder (MM/DD/YYYY)	

Part III - Policies and Payment

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. Your insurance policy is a contract between your insurance company and you. We cannot accept responsibility for negotiating settlement of insurance claims. You are responsible for prompt payment of any bills due to us, from this service provided to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT
I herewith authorize Leesburg Medical Clinic to furnish information to the insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by the insurance.

I herewith attest that the information provided by me, in Part 1 and Part 2 of this form, is accurate.

Name_____**Signature** _____ **Date** _____