Allergy Associates of Nothern Virgina, PLLC
1715 N George Mason Dr. Ste 307
Arlington, VA 22205

☐ New ☐ Update Information

Name of PCP:

Registration Form

FOR REFERRALS
Referring Physician:
Address/Phone:

PATIENT NAME (Last, First, MI)			TELEPHONE (home)		TELEPHONE (Mobile or Other)	
E-MAIL Address			EMPLOYER NAME		TELEPHONE (Work)	
ADDRESS			EMPLOYER ADDRESS			
CITY	STATE	ZIP	CITY		STATE	ZIP
DATE OF BIRTH	SEX ☐ Male ☐ Female	SOCIAL SECURITY NUMBER	EMPLOYMENT STATUS ☐ Full-Time ☐ Retired ☐ Part-Time ☐ Not Employed		PATIENT STUDENT STATUS If 19 Years of Older:	☐ Full-Time ☐ Part-Time ☐ Not a Student
MARITAL STATUS ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single	Age	EMERGENCY CONTACT Name:	Relationship:	Phone: Cell Phone:		

REPONSIBLE PARTY FOR BILLING (IF DIFFERENT THAN PATIENT)

RESPONSIBLE PARTY NAME (Last, First, MI)			SOCIAL SECURITY NUMBER	PATIENT RELATIONSHIP TO RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Child Other:
RESPONSIBLE PARTY ADDRESS (Street, Apt. No)			EMPLOYER NAME	TELEPHONE (Work)
CITY	STATE	ZIP	EMPLOYER ADDRESS (Street, Apt. No)	
TELEPHONE (home)	TELEPHONE (Emergency)		CITY	STATE ZIP

INSURANCE

PRIMARY INSURANCE IN WHOSE NAME?			DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED PARTY ☐ Self ☐ Spouse ☐ Child Other:
PRIMARY INURANCE CARRIER	TELEPHONE	GROUP NUMBER	POLICY ID NUMBER	Does your primary insurance require a require a referral to see a specialist? ☐ Yes ☐ No

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize Sally Joo Bailey, MD/Allergy Associates of N. Va to render needed treatment to the above named patient.
2. I authorize Sally Joo Bailey, MD/Allergy Associates of N. Va to release any medical or other information, as required in the course of examination or treatment, to process patient's claims. I also request payment of government benefits to either Sally Joo Bailey, MD/Allergy Associates of N.Va, who accepts assignment, or myself.
3. I authorize my insurance benefits to be paid directly to the treating physician. I understand that I am responsible for charges not covered by my insurance.
4. I understand that I am responsible for all charges incurred through Sally Joo Bailey, MD/Allergy Associates of N.Va. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. The patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier.
6. Divorce is between the two parents. The parent bringing in the child for their appointment will be responsible for all balances due.

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**