REGISTRATION FORM
(Please Print)

Quality Internal Medicine, PLLC
1860 Town Center Drive, Suite 255
Reston, Virginia 20190
Tax ID 14-2008482

Today's date:				PCP: **Anne Rose Eapen M.D.**	
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Div / Sep / Widow
Social Security No.:			Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:			Home phone: ( )		Cell phone : ( )
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone: ( )
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.	❑ Insurance Plan		❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**)

Name of Primary Insurance Co. :

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name: (if not patient)	Subscriber's S.S. no.:	Birth date: / /	**Group no.:**	**Policy no.:**	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name: Birth Date / /		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

BILLING INFORMATION

Person responsible for bill (if not patient):	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here?	❑ Yes ❑ No		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance/Medicare benefits be paid directly to the physician. I understand that I am financially responsible for any balance due. I also authorize Quality Internal Medicine or insurance company to release any information required to process my claims. Patient also agrees that his signature may be stored electronically as an original. As your internist, it is the policy of Quality Internal Medicine to routinely forward medical information to other health care providers involved in your care. This may involve communication of sensitive family history or personal history (such as alcohol or HIV status). In signing this consent, you agree to our being able to pursue this practice and in so doing, better maintain your continuity of care. In regards to Medicare, certain circumstances cause Medicare to decide that appropriate medical services are not medically necessary under Medicare Law. Since Medicare will deny payment for these services, I agree to be personally responsible.

_____ _____

Patient/Guardian signature *Date*