Washington Square

109 Park Washington Court, Falls Church, VA 22046
(703) 533-5824 Fax (703) 533-8431

NEW PATIENT REGISTRATION INFORMATION

Date First Seen:_____

PATIENT INFORMATION:

Patient's Name:_____
Last First Middle

Address:_____
Street Apt. City, State Zip

Home Phone #:( )_____ Work/School #:( )_____
___

Marital Status:_____S_____M____W____D____SEP Gender:____M____F

Date of Birth:_____ Social Security _____

Referred By:_____
Name Phone #

EMERGENCY CONTACT:_____
Name Phone #

FINANCIAL INFORMATION:

Financially Responsible Person:_____

Relationship to Patient:_____Self _____Parent _____Spouse _____Other

Address:_____
Street Apt# City, State Zip

Home Phone #:( )_____ Work #:( ) _____

INSURANCE INFORMATION:
(Please be advised that we do not file insurance, but this information is kept on file in case we are contacted by your insurance company)

Insured's Name:_____
Last First Middle

Insured's
Address:_____
Street Apt# City, State Zip

Insured's Date of Birth:_____ Social Security :_____

Relationship to Patient:_____Self _____ Parent _____ Spouse _____Other _____

Primary Insurance or Program Name:_____

Insurance Address for Claims Submission:_____

Insured's Group #:_____ Insured's ID #:_____

Signature on File Authorization

"I_____, request that payment of authorized insurance benefits be made to me or on my behalf to David A. Beigel, LPC for any services furnished to me by that practitioner or supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature_____

Date:_____