

REGISTRATION

LOEHMANN'S WALK-IN CLINIC, PLLC

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Falls Church, VA 22042
(703) 846-9555 - (703) 846-9557 Fax

DATE: _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
Address _____ E-mail: _____
City _____ State _____ Zip _____
Sex M F Age _____ Birth date _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Home Phone (____) _____ Cell Phone (____) _____
How do you find out about us GOOGLE SEARCH GOOGLE AD EMPLOYER FRIEND ROAD SIGN OTHER EXPLAIN _____
In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person responsible for account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birth date _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone(____) _____
City _____ State _____ Zip _____
ID # _____ Group# _____ Subscriber # _____
Person Responsible Employee by _____ Occupation _____
Insurance Company _____
Names of other dependents cover under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address (if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (____) _____
Insurance Company _____ Soc. Sec. # _____
ID # _____ Group# _____ Subscriber # _____
Names of other dependents cover under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s) have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ 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 authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient