Beauregard Medical Center

Ph: 703-820-7000 Fax: 703-931-0059

4660 Kenmore Avenue,
Ste 900, Alexandria, VA 22304

Patient Registration Form: www.beauregardmedicalctr.com

Personal Information

Social Security #:_____Date of Birth: _/ _/_____Age:_____Sex: M F Marital Status: M S W D

Patient's Name: Last_____First_____Mi_____

Patient's Address:_____ Apt#:_____

City:_____State:_____ ZIP:_____

Home Telephone:_____ Work Telephone:_____Ext_____ Cell:_____

Employer:_____ Occupation _____

Employment Address_____ City:_____State:_____ZIP: _____

Emergency Contact_____ Tel_____Relationship _____

Patients under the Age of 18

Parent or Guardian Name: Last_____First_____Mi_____

Home Telephone:_____ Work Telephone:_____Ext_____ Cell:_____

Insurance Information

Plan Name: Effective Date:_____/____/____ Primary Secondary

ID #_____Group #_____Plan Telephone _____

Address_____City_____State_____Zip_____

Policy Holder's Name_____ D.O.B_____/____/____SS#:_____-____-

Policy Holder's Employer_____Relationship to Patient_____

Plan Name: Effective Date:_____/____/____ Primary Secondary

ID #_____Group #_____Plan Telephone _____

Address_____City_____State_____Zip_____

Policy Holder's Name_____ D.O.B_____/____/____SS#:_____-____-

Policy Holder's Employer_____Relationship to Patient_____

Source of Referral

Whom Can We Thank For the Referral (Name)

- Physician:_____
- Insurance Company: _____
- Family/Friend: _____
- Phone Book: _____
- Internet: _____
- Other: _____

Other Information

Do you have an Advance Medical Directive? ☐ Yes ☐ No

If yes, please provide a copy for your record; If No, please ask for information.

May we contact you to confirm your appointment? ☐ Yes ☐ No

If yes, please indicate preferred Means of Contact and circle 1-2-3 in order of priority

Telephone. #_____Email Address:_____Text: _____

Is it okay to leave a Message on your voice mail reminding you of your appointment? ☐ Yes ☐ No

Assignment of Benefits and Authorization to Release Medical Information

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Beauregard Medical Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Beauregard Medical Center and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

_____ _____ _____

Signature Patient/ Policy Holder Date

Responsible Person if Patient is a Minor: _____