THE ENDOCRINE CENTER
CONCIERGE MEDICINE

3025 Hamaker Court • Suite 400 • Fairfax VA 22031
Phone (703) 873•7425 Fax (703) 873•7426 Email: info@novaendocenter.com
www.novaendocenter.com

New Patient Registration Form

A. PATIENT INFORMATION			
Last Name, First Name, Middle Initial		Date of Birth	Social Security number
Mailing address	City	State	Zip code
Primary phone # Cell Work Home	Secondary Phone # Cell Work Home		Email Address
Emergency Contact Name and Phone number		Relationship to patient	
Name of Primary Care Physician (PCP)	PCP contact info (phone and fax)		
Name of Referring Physician	Referring physician contact info (phone and fax)		

B. INSURANCE INFORMATION			
Primary Insurance Carrier	Date of Birth	ID or Policy Number	Group/Code
Subscriber's Name and relationship to patient		Subscriber's SSN	Effective Date
Secondary Insurance carrier (if applicable)	Date of Birth	ID or Policy Number	Group/Code
Subscriber's Name and relationship to patient		Subscriber's SSN	Effective Date

C. PHARMACY		
Name of Pharmacy	Pharmacy Address	Pharmacy phone number ( )
How did you hear about the practice? ☐ Friend/Relative ☐ Website ☐ Insurance carrier ☐ Other		

Patient Authorization

I hereby authorize The Endocrine Center, PC to release any information acquired in the course of my examination or treatment necessary to process insurance claims. I assign any benefits payable by my insurance carrier to the provider services submitting a bill for the services rendered. I further authorize the release of any necessary information, including medical for any related claim to the above insurance company. I accept financial responsibility for any collection/attorney fees the physician incurs in collecting payments for which I am responsible. A copy of this agreement may be used in place of the original. This authorization may be revoked at any time in writing. I certify that all the above information stated on this form is true and accurate.

_____ _____
Signature of Patient or Parent/Legal Guardian Date