☐New Patient
☐EstablishedPatient

Fairfax Neonatal Associates, P.C. - Please check Outpatient Division that the Patient is registering for:

__Pediatric Lung and Allergy Center __Pediatric Surgical Group __Pediatric and Adolescent Sleep Center

PATIENT REGISTRATION – DEMOGRAPHIC INFORMATION – PLEASE give insurance card(s) to Registrar/ Front Desk.

① **Patient:** **LAST NAME (write below):** **First Name:** **Middle Name:** **Date Of Birth:** Month / Day / Year **Age:**

Home/ Billing Address: Street:
City: State: ZIP:

Patient Home Phone:

Patient's Work Phone, if any:: Patient's Cell Phone, if any: Patient's Gender: Male☐ Female☐

Email Address (or Email for a Parent/Guardian if patient under age 18)

Please list any family members who are registered with this medical practice:

Is a written referral required by Patient's Health Plan?

② **REFERRING PROVIDER:** **Office Phone :** **FAX Number:**
Name:
Referring Office Address: City: State: ZIP:

③ **PRIMARY CARE PROVIDER:** **PCP Office Phone :** **PCP FAX Number:**
Name
PCP Office Address: City: State: ZIP:

④ **PRIMARY RESPONSIBLE PARTY:** First Name: Middle Name: Gender: Male ☐ Female ☐
Last Name:
Guarantor is the Patient's: Mother□ Father□ Grandparent□ Self□ Other□:

Address (1): If address same as patient address listed above, check □. City: State ZIP:

Home Phone: Work Phone: Mobile Phone: Email Address (do not use work email)

Birth Date: Month / Day / Year Social Security #: Employer: Occupation:

⑤ **OTHER PARENT/GUARDIAN (2)** First Name: Middle Name: Gender: Male ☐ Female ☐
Last Name:
Other Parent/Guardian 2 is the Patient's: Mother□ Father□ Grandparent□ Other□:

Address (2): If address same as patient address listed above, check □. City: State ZIP:

Home Phone: Work Phone: Mobile Phone: Email Address (do not use work email)

Birth Date: Month / Day / Year Employer: Occupation:

⑥ **EMERGENCY CONTACT:** (Other than Parent/Guardian listed above.) Relationship to Patient Daytime Phone #:
Name:

⑦ **PRIMARY INSURANCE PLAN:** Effective Dates of Coverage:
Company / Plan Name:
Subscriber: Last Name: **First Name:** **Subscriber Birth Date:** (Month /Day/ Year)
Patient's Relationship to Subscriber: Self□ Child□ Spouse□ Other□ **Cert / ID #:**
Group Name:/ Employer: **Group #:** **Plan Phone #:**

⑧ **SECONDARY INSURANCE PLAN:** **Check if No Other Health Insurance□** Effective Dates of Coverage:
Company / Plan Name:
Subscriber: Last Name: **First Name:** **Subscriber Birth Date:** (Month /Day/ Year)
Patient's Relationship to Subscriber: Self□ Child□ Spouse□ Other□ **Cert / ID #:**
Group Name / Employer: **Group #:** **Plan Phone #:**

⑨ I attest to the accuracy of the information provided herein, and authorize its use for the registration of the patient listed above. SEE NEXT PAGE.

PRINT NAME: ____ SIGNATURE: ____ Today's Date: ________________

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HEALTH RECORD INFORMATION – PLEASE COMPLETE ALL.

① Patient:	LAST NAME:	First Name:	Middle Name:	Date Of Birth: Month / Day / Year

1. Patient's Chief Complaint/Diagnosis:

2. When did "Chief Complaint" first occur? [Date of Onset]

3. Does the Patient have any **allergies**?
   □No
   □Yes
   Please list allergies:

4. Pharmacy Information:
   Pharmacy Name: ---
   Location/Address: ---
   Pharmacy Phone #: ---
   Pharmacy FAX #:

5. How did you hear about our practice?
   Please check all that apply.
   □ Referred by primary care provider
   □ Referred by other physician/other specialist:_______________________
   □ Directory from Health Insurance Plan/ Provider Network
   □ Our Medical Practice Website / Internet search
   □ Inova Physician Directory
   □ Family member and/or Friend referred me
   □ Health Fair
   □ Advertisement (Print / Internet) where?:________________________
   □ Other: Please describe:______________________________________

6. The **"Meaningful Use" of Electronic Health Records program** requires that medical offices record certain information for patients, including race and ethnicity.

   The race and ethnicity categories are determined by the federal government's Office of Management and Budget (OMB). According to OMB, race and ethnicity may be thought of in terms of social and cultural characteristics as well as ancestry, and should not be interpreted as being primarily biological or genetic in reference.
   This information is strictly collected to meet the E.H.R. program's measures and requirements. Please note that the E.H.R. program does not require us to communicate with the patient in his/her preferred language in order to meet the program's measure.
   For more information about the "Meaningful Use E.H.R." program, please visit: www.dmas.viginia.gov/content_pgs/pr-arra.aspx

   What is the patient's preferred language?
   □ English
   □ Spanish
   □ Other: please list:
   □ Decline to answer.

   Which category best describes the patient's race? (check any you feel apply).
   □ White
   □ Asian
   □ Black or African American
   □ American Indian/Alaska native
   □ Native Hawaiian/Other Pacific Islander
   □ Decline to answer.

   Does the patient consider herself or himself to be Hispanic / Latino?
   □ Yes - Hispanic/Latino
   □ No
   □ Decline to answer.

COMPLETED BY:

PRINT NAME: ____ Relationship to Patient:_______________________________________ Today's Date: ________________