NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office 703.876.0800 | Fax 703.876.0866 | After hours emergency 703.755.1450

Patient Information

Appointment Date:	Time of Appointment:	Marital Status: S M D W Sex: M F
Last Name	First Name	Middle Name
Birthdate (Mo/Day/Yr)	Social Security Number	
Race: ☐ White ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to say/Other		Ethnicity: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a
Home Address Street	City, State, Zip Code	Email Address
Home Phone ( )	Cell Phone ( )	Business Phone ( )
Employer Name	Employer Address Employer Phone: ( )	
With whom is your appointment?	Date of Onset of Condition	Appointment Reason
Referring MD Name		**Referring MD Phone Number** ( )
Primary Care Doctor Name		**Primary Care Doctor Phone Number** ( )

Primary Insurance Company	Primary Ins. Phone ( )	Primary Ins. Policy Number	Primary Ins. Group Number
Name of Insured Person - Primary Ins.	Birthdate of Insured-Primary	Social Security # of Insured Person-Primary	Relationship to Insured-Primary
Secondary Insurance Company	Secondary Ins. Phone ( )	Secondary Ins. Policy Number	Secondary Ins. Group Number
Name of Insured Person - Secondary Ins.	Birthdate of Insured - Secondary	Social Security # of Insured-Secondary	Relationship to Insured-Secondary
Nearest Relative to Contact in Case of Emergency	Address		Phone ( )

** IS THIS AN ACCIDENT/ AUTO ACCIDENT/ LEGAL CASE?	☐ YES	☐ NO
** IS THIS A WORKERS COMPENSATION CASE?	☐ YES	☐ NO
** ARE YOU A MEDICARE PATIENT?	☐ YES*	☐ NO *If yes, please complete the reverse side of this form.

I certify the above information is correct. I understand I am responsible to notify the Neurology Center of Fairfax, LTD if my insurance coverage changes, if benefits change, or if the coverage I have reported is incorrect. I understand and agree that I am ultimately responsible for payment in full for services I receive from the Neurology Center of Fairfax, LTD.

Patient Signature	**Date**

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Patient Name: Date of Birth:

MEDICARE PATIENTS ONLY

Are you in a rehabilitation facility?	☐ YES	☐ NO
Are you in a skilled nursing facility?	☐ YES	☐ NO
Are you in a nursing center?	☐ YES	☐ NO
Are you in hospice?	☐ YES	☐ NO

*If yes, please provide the name and address of the facility in the spaces below:

Facility Name:
Facility Address: