NEUROLOGY CENTER OF FAIRFAX, LTD.

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After hours emergency 703.755.1450

Patient Demographic Form

PATIENT INFORMATION			Patient#		Account #		
Last Name:				Suffix:			
First Name:		Mid. Initial:		DOB:		Sex:	
Home Address1:				Age:			
Apt/Suite #:				Home Tel#:			
City, State, Zip:				Work Tel#:			
Email:				Cell Tel#:			
Race:		Ethnicity:		Language:			

HOW DO YOU PREFER YOUR APPOINTMENT REMINDER (please check boxes below)			
Preferred Phone Method:	Home ☐ Work ☐ Cell ☐	Communicate by:	Phone ☐ Email ☐ Text ☐

EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)					
Name:		Tel #		Relationship:	

PRIMARY INSURANCE			
Plan/Policy Name:		Group #:	
Plan Tel#:		Subscriber DOB:	
Subscriber Name:		Subscriber ID:	
Relationship to Patient: (check box)	☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other		

SECONDARY INSURANCE			
Plan/Policy Name:		Group #:	
Plan Tel#:		Subscriber DOB:	
Subscriber Name:		Subscriber ID:	
Relationship to Patient: (check box)	☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other		

Additional Information

Accident/Auto Accident/Legal Case?	**YES** ☐	**NO** ☐	Primary Doctor:	_____
Workers Compensation Case?	**YES** ☐	**NO** ☐		
Are you a Medicare Patient?	**YES** ☐	**NO** ☐	Referring Doctor:	_____

MEDICARE PATIENTS ONLY

Are you in a Rehabilitation facility?	**YES** ☐	**NO** ☐	Facility Name & Address	_____
Are you in a Skilled Nursing facility?	**YES** ☐	**NO** ☐	Facility Name & Address	_____
Are you in a Nursing Center?	**YES** ☐	**NO** ☐	Facility Name & Address	_____
Are you in Hospice?	**YES** ☐	**NO** ☐	Facility Name & Address	_____

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 or authorized person's signature: _____ **Date:** _____