PINNACLE FAMILY PRACTICE

13135 Lee Jackson Memorial Hwy #202 | Fairfax, VA 22033 | Phone 703-429-2901 | Fax 703-429-2902

Personal Information:

Name: _____ Date of Birth: _____ ( ) Male ( ) Female

SS#:_____ Driver's License #:_____Expiration date: _____State: _____

If child, name of Parents: _____

Address: _____ Marital Status: ( ) single ( ) married ( ) divorced ( ) widowed

City/State/Zip: _____

Emergency Contact_____Relationship_____

Emergency Contact Phone Number Home ( ) Work ( ) Cell ( ) _____

Patient Phone: Home: _____ Cell:_____ Work:_____

Email: _____

Preferred way to receive calls: ( ) Cell ( ) Home ( ) Work

Preferred way to receive appointment reminders: ( ) email (Cell phone/voice mail) ( ) home phone/voice mail

Employment Information

Employer: _____Occupation_____

Address: _____

Insurance Information: _____No Insurance: check here ( )

Primary Insurance Company: _____ phone #: _____

ID#_____ Group #:_____

Insurance address: _____

Name of Policy Holder_____ Relationship to patient: _____

SS#:_____ Date of Birth: _____ Employer: _____

Secondary Insurance Company: _____ phone #: _____

ID#_____ Group #:_____

Insurance address: _____

Name of Policy Holder_____ Relationship to patient: _____

SS#:_____ Date of Birth:_____ Employer:_____

Lifetime authorization to release Information and assign benefits:

I request the payment of insurance benefits be made on my behalf to Pinnacle Family Practice, LLC for any services furnished to myself/my child (if patient is under age 18) by the health provider of PFP who accepts this assignment. I authorize any holder of medical information about myself/my child to release to my insurance carrier any information needed t determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. This authorization maybe revoked by either me or my insurance carrier at any time in writing.

I will pay for any balance due on services rendered which are not covered by my insurance plan. If my account is released to a collection agency for non-payment of any balances, I will be responsible for the collection agency's fee.

Signature: _____ Date: _____