1715 N. George Mason Dr.
Ste 408
Arlington, VA 22205

Massoud Saberinia, M.D

9001 Digges Rd
Ste 208
Manassas, VA 20110

PATIENT REGISTRATION

PATIENT NAME: FIRST	M.I.	LAST	MALE / FEMALE? M or F	SOCIAL SECURITY #	DATE OF BIRTH

HOME ADDRESS	APT #	CITY	STATE	ZIP	HOME PHONE

EMPLOYER	ADDRESS	WORK PHONE

OCCUPATION	REFERRED BY: FIRST and LAST NAME	CELL PHONE

ALLERGIES TO MEDICATIONS	PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known)	MARITAL STATUS ____S ____M ____W ____D

SPOUSES NAME	WORK PHONE:	OCCUPATION

PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)	TELEPHONE

POLICY HOLDER NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	FINANCIALLY RESPONSIBLE PERSON ___PATIENT ___SPOUSE ___PARENT ___OTHER

EMPLOYER	ADDRESS	WORK PHONE

Primary Insurance Billing Information

Ins. Co. Name_____

Address:_____

City, State & Zip:_____

ID.No:_____

Group Name:_____Group #:_____

Subscriber:_____
(Person's Name)

Subscribers Date of Birth:_____

Subscriber's Social Security #

Secondary Insurance Billing Information

Ins.Co. Name_____

Address:_____

City, State & Zip:_____

ID.No:_____

Group Name:_____Group#_____

Subscriber:_____
(Person's Name)

Subscriber's Date of Birth:_____

Subscriber's Social Security #

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Massoud Saberinia, M.D. to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

I understand that I will be responsible for a charge of $35.00 for missed appointments without at least 24 hour prior cancellation notice. I certify that the information I provided above is correct.

_____ _____

Date *Signature of Subscriber or Beneficiary*

_____ _____

Date *Signature of Patient*