INOVA

**Patient Information:**

Name (last, first, middle initial): ______________ Email Address: ______________

Address: ______________ Apt # ______ City: ______ State: ______ Zip Code: ______

Date of Birth: ______ Age: ____ Sex: ☐ Male ☐ Female Social Security Number: ______ Preferred Language: ______

Phone Number (home): ______________ Phone Number (alternate): ______________ ☐ cell ☐ work

Specify number for reminder messages: ☐ home ☐ alternate I permit reminder calls to be left on my voicemail: ☐ yes ☐ no

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired Employer: ______________
☐ Student ☐ Other ______________

Emergency Contact: ______________ Relationship to Patient: ______________

Address: ______________

Phone Number (home): ______________ Phone Number (alternate): ______________ ☐ cell ☐ work

**Demographics:** Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ More than one race ☐ Hispanic ☐ Declined ☐ Other ______________

Ethnicity: ☐ American ☐ Asian Indian ☐ Caribbean Islander ☐ Chinese ☐ Eastern European ☐ Filipino
☐ Japanese ☐ Korean ☐ Middle Eastern ☐ North African ☐ Pakistani ☐ Vietnamese
☐ West African ☐ Declined ☐ Other ______________

**Insurance Information – We will request to scan your ID and insurance card.**

Primary Insurance: ______________ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Member ID # ______________ Provider/Insurance Services Phone Number ______________

Secondary Insurance: ______________ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Member ID # ______________ Provider/Insurance Services Phone Number ______________

**Insured Information (if other than patient):**

Subscriber/Policy Holder: ______________ Relationship to Patient: ______________

Address: ______________

Social Security Number: ______________ Date of Birth: ______________ Subscriber Employer: ______________

Please indicate your referring provider in addition to other providers who will need your treatment information.

Primary Care Provider Name: ______________

Address: ______________ Phone Number: ______________ Fax Number: ______________

Specialty Care Provider Name: ______________ Specialty: ______________

Address: ______________ Phone Number: ______________ Fax Number: ______________

Specialty Care Provider Name: ______________ Specialty: ______________

Address: ______________ Phone Number: ______________ Fax Number: ______________

**Patient/Parent/Guardian** (signature): ______________ Date: ______________ Time: ______________

**Patient/Parent/Guardian** (print name): ______________ Relationship: ______________

**Interpreter Information** (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) ______________

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________

Date of Birth: ______________ Medical Record # ______________

Gender: ❑ Male ❑ Female

## Inova Medical Group

# Patient Registration Form

IMG Location: ______________

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