Capital Area Physician Weight & Wellness Center

Ph: (703) 255-6010 Fax: (703) 255-6011
www.capwwc.com
124 Park Street Southeast, Suite 203, Vienna, VA 22180
44121 Harry Byrd Highway, Suite 250, Ashburn, VA 20147
Ph: 703.255.6010 Fax: 703.255.6011

Personal Information

Patient's Last Name:_____ Middle: _____ First:

SSN#:_____DOB:_____Age:_____Sex: □ M □ F Marital Status: □M □ S □ W □ D

Race: _____ Ethnicity: (Check one) □ Hispanic □ Non-Hispanic □ Asian □ Black □ Caucasian □ Other

Home Address: _____(City)_____(Zip code)

Home Telephone:_____ Work Telephone:_____ Cell:_____

Local Pharmacy Name/Address/Telephone: _____

Patient Email: _____Preferred way of communication: _____

Emergency Contact : (Name)_____(Relationship)_____ (Tel)_____

Employer: _____ Occupation: _____

Employment Address _____ City: _____State: _____ ZIP: _____

Patient's under the Age of 18
Parent or Guardian Name: Last---------- First…… Middle----------

Billing and Insurance Information

1) Primary Insurance: _____ Policy# _____ Group#_____

Policy Holder's Address_____

Policy Holder's Name _____ Date of Birth: _____ SSN: _____

Relationship to Insured: □SELF □ SPOUSE □ CHILD □ OTHER_____

2) Secondary Insurance: _____ Policy# _____ Group#_____

Policy Holder's Address_____

Policy Holder's Name _____ Date of Birth: _____ SSN: _____

Relationship to Insured: □ SELF □ SPOUSE □ CHILD □ OTHER_____

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Whom Can We Thank For the Referral (Name?)

□ PHYSICIAN □ INSURANCE COMPANY □ FAMILY □ FRIEND □ INTERNET □ OTHER _____

_____

Do you have an Advance Medical Directive? □ **Yes** □ **No**

Please provide a copy for our record; If No, please ask for information.

Assignment of Benefits and Authorization to Release Medical Information

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Capital Area Internal Medicine Inc (dba Capital Area Physician Weight & Wellness Center). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Capital Area Internal Medicine, Inc. (dba Capital Area Physician Weight & Wellness Center) and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

_____ _____ _____

Signature **Patient/ Policy Holder** **Date**

Responsible Person if Patient is a Minor: _____