

Complete this form online. Bring it to your appointment or fax it to the office. Use the PRINT button at the bottom.

Adult & Pediatric Allergy of Northern Virginia  
100 Elden Street, Suite 10  
Herndon, VA 20170

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
Sex: F M Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Personal Physician: \_\_\_\_\_

FOR THE CHILDREN UNDER THE AGE OF 18: In the event of an emergency, and I cannot be contacted, I give my permission to the doctors of the persons under their instruction to treat my child in their office or hospital as required by the events of that emergency situation.

Parent's signature: \_\_\_\_\_

Print and sign the form.

### GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Sex: F M Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Name: \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_ SS#: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_ SS#: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### MEDICAL RELEASE AUTHORIZATION

I authorize the Adult and Pediatric Allergy Center of Northern Virginia to apply for benefits on my behalf for covered services rendered. I request payment be made directly to the above-named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent and/or the insurance company named above. I permit a copy of this authorization to be used in place for the original. This authorization may be revoked by either me or the above named carrier at any time in writing. I understand I will be responsible for all charges made for services as well as all costs of collections and reasonable attorney fees (minimum \$15) if this account is placed in the hands of an attorney.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PRINT