TOWN CENTER ORTHOPAEDIC ASSOCIATES, P.C.

Jeffrey H. Berg, M.D. • Stephanie Y. Clop, M.D. • Thomas B. Fleeter, M.D.
George Kartalian, Jr., M.D. • David R. Miller, M.D.
Dhruv B. Pateder, M.D. • Raymond Thal, M.D.

1860 Town Center Drive • Suite 300 • Reston, VA 20190
6201 Centreville Road • Suite 600 • Centreville, VA 20121

PATIENT ACCOUNT NUMBER
DATE / /

B - C - F - K - M - P - T

PATIENT INFORMATION - PLEASE PRINT CLEARLY

PATIENT NAME: *Last*	*First*	*Middle Initial*	SEX: ❑ M ❑ F	DOB:	AGE:
ADDRESS: *Number & Street*					*Apt.#*
City:	*State & Zip*	MARITAL STATUS: ❑ S ❑ M ❑ W ❑ D	SOCIAL SECURITY NUMBER:		
HOME PHONE: ( )	WORK PHONE: ( )	CELL PHONE: ( )	EMAIL ADDRESS:		

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	GRP#	ID#
SUBSCRIBER'S NAME DOB:	WORK PHONE & EXTENSION ( )	RELATIONSHIP TO PATIENT
SUBSCRIBER'S EMPLOYER & ADDRESS		

SECONDARY INSURANCE INFORMATION OR WORKER'S COMPENSATION INFORMATION

INSURANCE COMPANY NAME OR WORKER'S COMPENSATION CARRIER	GROUP# OR DATE OF INJURY	ID# OR CLAIM #
SUBSCRIBER'S NAME DOB:	WORK PHONE & EXTENSION ( )	RELATIONSHIP TO PATIENT
SUBSCRIBER'S EMPLOYER & ADDRESS		

GENERAL INFORMATION

REQUESTING PHYS.	FAMILY PHYSICIAN (REQ'D FOR HMO & MEDICARE PTS.)	ADDRESS & PHONE NUMBER IF KNOWN
ALLERGIC TO ANY MEDICATIONS? Y N *Please List:*	INJURY OR SYMPTOMS (i.e. fractured arm, left knee pain, etc.)	
DATE OF INJURY OR SYMPTOMS? (REQ'D) MO. /DAY /YR.	WHERE DID ACCIDENT OR INJURY OCCUR?	AUTO ACCIDENT? ❑ Y ❑ N
CONTACT PERSON IN CASE OF RESCHEDULING OR EMERGENCY (PLEASE PROVIDE)		
TELEPHONE NUMBER ( )		
RELATIONSHIP		

I authorize the release of any medical information necessary to process insurance claim forms. I authorize payment of medical benefits to Town Center Orthopaedic Associates, P.C. for services rendered.

Unless we participate with your insurance, payment in full is expected when service is rendered. Whether or not your insurance company makes payment is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment.

I accept responsibility for any patient balance. I understand that if the balance due is not paid as described above, I will be responsible for any collection and / or attorney fees that are incurred in the attempt to collect this debt.

SIGNATURE ______________________ SS#: ______________ DATE: ____ / ____ / ____

PRINTED NAME: ______________________ RELATIONSHIP TP PATIENT: ______________
(Req. when signing for minors)

ADDRESS: ______________________ PHONE: ( ) ______________