National Scoliosis Center/3-D Body Imaging, LLC

3023 Hamaker Court, Suite LL-50, Fairfax, Virginia 22031
Office (703) 849-8808 Fax (703) 942-6062

Patient Registration *PLEASE PRINT CLEARLY –COMPLETE ALL AREAS*

Last Name	First Name	Middle Initial	Date of Birth	Age

Home Address Apt #	City	State	Zip

Social Security Number	Sex	Marital Status ❒S ❒M ❒D ❒W	Home Phone Number ( )	Cell Phone Number ( )

Employer (or previous employer, if retired) ❒Self ❒Military ❒Retired ❒P/T ❒F/T	Student Status ❒P/T ❒F/T	Work Phone Number ( )

Employer Address	City	State	Zip

Primary Care Physician Name	Referring Physician/Specialist Name	How did you hear about us

Responsible Party Information *(Person Responsible for Bill)* ☐***Same as patient*** *(check box)*

Name *Last* *First* *Middle Initial*	Date of Birth	Social Security Number	Sex

Relationship to Patient	Home Phone ( )	Work Phone ( )	Cell Phone ( )

Home Address Apt #	City	State	Zip

Email Address

Primary Insurance Information: *(Primary Subscriber)* ☐***Same as responsible party*** *(check box)*

Name of Insurance Company	Effective Date:

Insurance Company Address	City	State	Zip

Group Number	Policy Number	Subscriber Information *(if other, please state relationship and complete following information)* ❒Same as patient ❒Same as responsible party ❒Other:_____

Subscriber's Name *Last* *First* *Middle Initial*	Date of Birth	Social Security Number	Sex

Employer	Home Phone Number ( )	Work Phone Number ( )

Secondary Insurance Information:

Name of Insurance Company	Copay Amount $	Effective Date

Insurance Address	City	State	Zip

Group Number	Policy Number	Subscriber Information *(if other, please state relationship and complete following information)* ❒Same as patient ❒Same as responsible party ❒Other:_____

Subscriber's Name *Last* *First* *Middle Initial*	Date of Birth	Social Security Number	Sex

Employer	Home Phone Number ( )	Work Phone Number ( )

I certify that the information reported above is correct and complete and that I will notify National Scoliosis Center, immediately of any changes.

Signature of Patient/Parent/Guardian/Guarantor _____ Print Name _____ Date _____

REVISED 05/2016