National Scoliosis Center/3-D Body Imaging, LLC

3023 Hamaker Court, SUITE LL-50 | Fairfax VA, 22031 | (703) 849-8808 PHONE | (703) 942-6062 FAX
100 West Road, SUITE 202 | Towson MD, 21204 | (410) 832-3377 PHONE | (443) 652-3787 FAX

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	Home Phone Number	Cell Phone Number
		❒S ❒M ❒D ❒W	( )	( )

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

Employer Address	City	State	Zip

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

Email (If adult)

Parent/Guardian 01 *OR* Patient's Spouse

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

Parent/Guardian 02

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:

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
	( )	( )

❒ *I have multiple insurances (Check Box)* ❒ *I have a Carefirst BlueCross BlueShield insurance plan (Check Box)*

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 _____

Updated 02/06/2019

National Scoliosis Center/3-D Body Imaging, LLC

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 ( )	

Tertiary 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 ( )	

Insured or Authorized Person(s) Signature:

- **I authorize payment of medical benefits to the undersigned physician or supplier for services.**

_____ _____ _____

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

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

Updated 02/06/2019