S. TARIQ SHAHAB, MD

VASCULAR AND INTERVENTIONAL CARDIOLOGY
8501 Arlington Blvd., Ste 330 FairFax, VA 22031

PATIENT REGISTRATION

DO YOU HAVE A LIVING WILL? YES___ NO___ INITIALS___

PATIENT NAME:	M.I.	LAST	DATE OF BIRTH	MALE/FEMALE M_____F_____

HOME ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	Phone #1 ___home___cell___work	PHONE # 2 ___home ___cell ___work

E-mail address	OCCUPATION

PRIMARY PHYSICIAN: FIRST and LAST NAME	REFERRED BY: FIRST and LAST NAME

PHARMACY NAME AND ADDRESS

PERSON TO CONTACT IN CASE OF EMERGENCY	TELEPHONE

POLICY HOLDER NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

Primary Insurance Billing Information

Ins. Co. Name	

ID. No:	

Group Name:	Group #:

Secondary Insurance Billing Information

Ins. Co. Name	

ID. No:	

Group Name:	Group#

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with the office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize S. Tariq Shahab, M.D. to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

Signature of Subscriber or Beneficiary **Date**

I acknowledge that I have been offered a copy of the privacy notice of S. Tariq Shahab, M.D. **Copy Taken_____Copy Decline_____**

Signature of Patient **Date**