RESTON MEDICAL ASSOCIATES, LTD.

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☐ *New Patient*
☐ *Update*

☐ Gwilym Parry, MD.
☐ Tessa Cholmondeley, MD.

Patient Demographic Form

This document if part of your permanent record.

By law, we are required to collect this information from every patient treated in our facility.
Please assist us by completing the form below.

Patient Full Legal Name: _____ **DOB**:____/____/_____ **Age**:_____

Patient Address: _____

City: _____ **State**: _____ **Zip**: _____

Patient SS #: _____ - _____ - _____ **Marital Status**:☐**S**☐**M**☐**D**☐**W** **Gender**:☐**M**☐**F**

How do you identify yourself? (Please choose all that apply.)

Race:

☐ American Indian ☐ Native Hawaiian or Pacific Islander ☐ Other, please specify _____
☐ Black or African American ☐ White ☐ Asian ☐ Decline to Answer

Ethnicity:

☐ Hispanic or Latino ☐ Other, please specify _____
☐ Non Hispanic or Non Latino ☐ Decline to answer

Home Phone #: _____ **Cell Phone#**: _____

Email: _____

Employer: _____

Employer Phone number: _____

Pharmacy Name/address/phone number: _____

Spouse's Name: _____ **Spouse's Employer**: _____ **Work Tel. #**: _____

Emergency Contact Name: _____ **Relationship**: _____

Emergency Contact Phone number: _____

Allergies: _____ **Referred by**: _____

Health Insurance? _____ **Self pay**? _____

WE REQUEST PAYMENT AT THE TIME OF SERVICE FOR ALL SERVICES RENDERED. PLEASE READ AND SIGN BELOW.

I consent to the evaluation and treatment by the Physician(s) and staff of Reston Medical Associates.
I understand and agree that I am financially responsible for all charges whether or not covered by insurance.

I hereby authorize Reston Medical Associates to release any necessary information, including medical information for this or any related claim, to my insurance carrier (or, in the case of Medicare Part B benefits to the Social Security Administration and the Health Care Financing Administration)

In the event that Reston Medical Associates submits a claim, I authorize payment of all medical insurance benefits which are payble to me under the terms of my insurance policy to be paid directly to the Physician who rendered services. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or by the above named carrier at any time in writing.

Signature: _____**Date**:_____