FAIRFAX LUNG CENTER

New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____ ☐ M / ☐ F Social Security #_____

Address _____

Street City State Zip

Phone: Home (____) _____ Work (____) _____

Cell: _____ Email_____

Occupation _____ Employer _____

Address _____ Phone (____) _____

Preferred Method of Contact:

☐ Phone (Home, Cell, or Work) ☐ Email ☐ Text

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer _____

Address _____ Phone (____) _____

(If different from above)

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____

Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____

Referred by: ☐ Friend/Relative _____ ☐ Doctor _____

Name Name

Complete if under 18 years or a student

Name of Father _____ Employer _____

Address _____ Phone (____) _____

Name of Mother _____ Employer _____

Address _____ Phone (____) _____

INSURANCE INFORMATION

☐ Medicare #_____ ☐ Medicaid # _____

☐ Other Medical Insurance _____

*Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____ DOB _____