

- New Patient
- Update

**Medical Associates of Reston, Ltd.**  
**1800 Town Center Drive, Suite 212**  
**Reston, VA 20190**  
**703-435-2227**

- Lynne L. Fagan, M.D.
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- Julie L. Farley, M.D.

**PATIENT REGISTRATION**

<b>Patient Name:</b> <b>First</b> <b>Middle</b> <b>Last</b>				<b>Home Phone</b>				
<b>Home Address</b>			<b>City</b>		<b>State</b>		<b>ZIP</b>	
<b>Employer</b>		<b>Address</b>			<b>Cell Phone</b>		<b>Work Phone</b>	
<b>Occupation</b>	<b>Social Security No.</b>		<b>Marital Status</b> S   M   D   W		<b>Date of Birth</b>		<b>Age</b>	<b>Sex</b> M F
<b>Preferred Pharmacy:</b>	<b>Pharmacy Information (city, state, phone number)</b>				<b>E-mail Address</b>			
<b>In Case Of Emergency, Contact:</b>					<b>Phone</b>			
<b>Allergies</b>				<b>Referred by</b>				
<b>Spouse's Name</b>		<b>Spouse's Employer</b>			<b>Work Phone</b>			
<b>Financially Responsible Person</b> Patient   Spouse   Parent   Other	<b>Name (If Different From Patient)</b>			<b>Home Phone</b>		<b>Work Phone</b>		
<b>Financially Responsible Person's Address (If Different From Patient)</b>								
<b>Medicare</b>				<b>Other Insurance</b>				
<b>I.D. No.:</b> _____		<b>Ins Co Name</b> _____						
<b>Effective Date</b> _____		<b>Address</b> _____						
		<b>City, State, ZIP</b> _____						
		<b>I.D. No:</b> _____						
<b>Medicaid</b>		<b>Group</b> _____						
<b>I.D. No:</b> _____		<b>Subscriber</b> _____						

**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 physicians and staff of Medical Associates of Reston.  
I understand and agree that I am financially responsible for all charges whether or not covered by insurance.

I hereby authorize Medical Associates of Reston (MAR) 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) or, in the case of workers compensation, to my employer in order to settle medical claims on my behalf.

In the event that MAR submits a claim, I authorize payment of all medical insurance benefits which are payable 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 \_\_\_\_\_