Roberta L. Gartside M.D.
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Phone (703) 742-8004
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Patient Information

* PLEASE COMPLETE ALL FIELDS *

Requesting/Referring Physician		Primary Care Physician		
Patient Legal Name (First MI Last)		Patient SS#		Patient Date of Birth
Nickname	☐ Mr. ☐ Ms. ☐ Mrs.	☐ Female ☐ Male	☐ Single ☐ Married	☐ Divorced ☐ Widowed
Address		Home Phone#		Work Phone#
City, State, Zip		Pager #		Cell #
Race ☐ White ☐ Black or African American ☐ Other Pacific Islander ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian				Ethnicity ☐ Non Hispanic ☐ Hispanic
Religious Preference		E-mail Address: by providing you have given permission to use		
Employer	Occupation		Employer Phone #	
Employer Address				

Insured/Subscriber Information

Legal Name (First MI Last)	Relationship	Date of Birth
Address (if different than above)	Home Phone#	SS#
City, State, Zip	Work Phone#	Cell #
Employer Name & Occupation	Employer Address	

Emergency Contact Information: Relative/Friend, **not living with you** (In case we are unable to contact you, or need to contact someone regarding your care in an emergency.

Contact Name	Phone #	Relationship to Patient
Address	City	State, Zip

Insurance Information

*** Call Insurance If You Do NOT Know Your Specialist Copay ***	**Primary Insurance**	**Secondary Insurance**
Insurance Name:		
Mailing Address for Claims:		
Insurance Phone #:		
Policyholder Name:		
Policyholder Date of Birth:		
Policyholder Relationship to Patient:	☐ Self ☐ Child ☐ Spouse ☐ Other	☐ Self ☐ Child ☐ Spouse ☐ Other
Policyholder Employer:		
Group #:		
Subscriber ID#:		
Is this part of an exchange	☐ YES ☐ NO	☐ YES ☐ NO

I understand that I am responsible for all charges. I will furnish this office with all information necessary to bill my insurance. Any balance after insurance has paid or denied is due by me. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the reasonable cost of collection, to include attorney fees. I understand that my insurance benefits and referral requirements are my responsibility and that all copayments are due at the time of service.

I authorize payment of medical benefits to physician for these services and all future claims and I authorize the release of any medical information necessary to process this claim and all future claims.

_____ _____

Signature (Must be a parent or guardian for children 17 and under) **Date**