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Adult Patient Registration Today's Date: _____

Last Name:	First Name:	MI:
Home Address Street:	Social Security Number:	Birthdate: _____ Age: _____ Sex: _____
City: _____ State: _____ Zip: _____	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Home Telephone Number:
Cell Phone: _____ Text Message: <input type="checkbox"/> Yes / <input type="checkbox"/> No	Email:	
Emergency Contact Name:	Relationship: _____ Home Phone: _____	Work Phone: _____

Pharmacy Address with Zip Code and Telephone Number	Occupation
Employer Name	Work Phone

Insurance Information

Name of Health Insurance Policy Holder (if different than patient)		Policy Holder Social Security No.	DOB
Address (Street, City, State, Zip)		Home Phone	Work Phone
Primary Health Insurance Co.	Policy Holder Name	Relationship to Patient	Plan Type <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Neither
Insurance Company Address	ID Policy No.	Group Number	Effective Date
Secondary Health Insurance Co.	Policy Holder Name	Relationship to Patient	Plan Type <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Neither
Insurance Company Address	ID Policy No.	Group Number	Effective Date

Family Physician	Referred by	Address	Phone
Any member of your family treated by our group before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your current problem:	Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Case? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Automobile Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	

If Due to Work Related Injury

Date of Injury	Was injury reported to Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Supervisor
Employer at time of injury	Employer Address (Street, City, State, Zip)	Phone
Description of injury		
Workers' Compensation Insurance Carrier		Claim No.
Workers' Compensation Insurance Carrier Address (Street, City, State, Zip)		Phone
Is an attorney assisting you with this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attorney's Name	Attorney's Phone Number
Signature and Name of Person completing form Print: _____ Signature: _____		Date