FOXHALL
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David M. Hansen, M.D. • Thomas L. Sacks, M.D. • Lucy M. McBride, M.D. • John A. Dooley, M.D.

I PLAN TO BE A PATIENT OF:

- ☐ Dr. Restifo
- ☐ Dr. Chester
- ☐ Dr. Klein
- ☐ Dr. Naujokaitis
- ☐ Dr. Umhau
- ☐ Dr. Schubert
- ☐ Dr. Ungar
- ☐ Dr. Li
- ☐ Dr. Yau
- ☐ Dr. Thomas
- ☐ Dr. Hansen
- ☐ Dr. Sacks
- ☐ Dr. McBride
- ☐ Dr. Dooley

Date:

PLEASE PRINT CLEARLY

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Prof. ☐ Other _____ ☐ Single ☐ Married ☐ Other _____

PATIENT'S NAME (LAST, FIRST, MIDDLE)					HOME PHONE ( )	
PATIENT'S HOME ADDRESS	APT. NO.	CITY	STATE	ZIP	BUSINESS PHONE ( )	
DATE OF BIRTH	SOCIAL SECURITY NUMBER				AGE	SEX
PATIENT'S OCCUPATION	PATIENT'S EMPLOYER'S ADDRESS					
SPOUSE'S NAME (LAST, FIRST, MIDDLE)					BUSINESS PHONE ( )	

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL	ADDRESS	CITY	STATE	ZIP	HOME PHONE ( )
RELATIONSHIP TO PATIENT	RESPONSIBLE PERSON'S EMPLOYER				BUSINESS PHONE ( )

PERSON TO NOTIFY IN CASE OF EMERGENCY	ADDRESS	CITY	STATE	ZIP	HOME PHONE ( )
RELATIONSHIP TO PATIENT					BUSINESS PHONE ( )

REFERRED BY

MEDICARE – IS MEDICARE YOUR PRIMARY INSURANCE? YES ☐ NO ☐

IDENTIFICATION NUMBER _____

WHICH DO YOU HAVE?
PART A ☐
PART B ☐

PLEASE INDICATE
Effective Date _____
Effective Date _____

BLUE CROSS INSURANCE – IS BLUE CROSS YOUR PRIMARY ☐ SECONDARY ☐ TERTIARY ☐

INSURANCE COMPANY NAME		PLEASE INDICATE WHICH STATE	GOVERNMENT POLICY YES ☐ NO ☐
IDENTIFICATION NUMBER	SERVICE OR ENROLLMENT NO. OR GROUP NO.		EFFECTIVE DATE OF CONTRACT
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTHDATE	SUBSCRIBER'S RELATIONSHIP TO PATIENT	SUBSCRIBER'S EMPLOYER

OTHER INSURANCE – IS THIS YOUR PRIMARY ☐ SECONDARY ☐ TERTIARY ☐

INSURANCE COMPANY NAME		PLEASE INDICATE WHICH STATE	GOVERNMENT POLICY YES ☐ NO ☐
IDENTIFICATION NUMBER	SERVICE OR ENROLLMENT NO. OR GROUP NO.		EFFECTIVE DATE OF CONTRACT
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTHDATE	SUBSCRIBER'S RELATIONSHIP TO PATIENT	SUBSCRIBER'S EMPLOYER

☐ **CHECK HERE IF YOU HAVE NO INSURANCE COVERAGE**

☐ **CHECK HERE IF YOU HAVE A LIVING WILL.**

I UNDERSTAND THAT FOXHALL INTERNISTS, P.C. DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANY.

I acknowledge I have read the above statement. I further acknowledge that I am personally responsible for payment of all charges not paid in full by insurance.

_____
PATIENT / GUARDIAN SIGNATURE

PIF 1/06