

Mary Restifo, M.D. • Alexander C. Chester, M.D. • Lawrence E. Klein, M.D. • Saulius Naujokaitis, M.D. • Andrew N. Umhau, M.D.
 Linda L. Yau, M.D. • David M. Hansen, M.D. • Lucy M. McBride, M.D. • John A. Dooley, M.D.
 Assil S. Saleh, M.D. • Matthew A. Parker, M.D. • D. Clay Ackerly, M.D.

I PLAN TO BE A PATIENT OF:

<input type="checkbox"/> Dr. Restifo	<input type="checkbox"/> Dr. Umhau	<input type="checkbox"/> Dr. Dooley
<input type="checkbox"/> Dr. Chester	<input type="checkbox"/> Dr. Yau	<input type="checkbox"/> Dr. Saleh
<input type="checkbox"/> Dr. Klein	<input type="checkbox"/> Dr. Hansen	<input type="checkbox"/> Dr. Parker
<input type="checkbox"/> Dr. Naujokaitis	<input type="checkbox"/> Dr. McBride	<input type="checkbox"/> Dr. Ackerly

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	CELL PHONE ()
PATIENT'S OCCUPATION		PATIENT'S EMPLOYER'S ADDRESS		EMAIL	
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?	PLEASE INDICATE
_____	PART A <input type="checkbox"/>	Effective Date _____
	PART B <input type="checkbox"/>	Effective Date _____

BLUE CROSS INSURANCE – IS BLUE CROSS YOUR PRIMARY SECONDARY TERTIARY

INSURANCE COMPANY NAME	PLEASE INDICATE WHICH STATE	GOVERNMENT POLICY	
		YES <input type="checkbox"/>	NO <input type="checkbox"/>
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 <input type="checkbox"/>	NO <input type="checkbox"/>
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