FOXHALL
INTERNISTS, P.C.

3301 New Mexico Avenue, N.W. • Suite 348
Washington, D.C. 20016
Phone 202.362.4467 • Fax 202.362.2303

Mary Restifo, M.D. • Alexander C. Chester, M.D. • Lawrence E. Klein, 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.• Sandra Delistathis, M.D.
Delia R. Fine, M.D.• Veronica A. DiFresco, M.D.

I PLAN TO BE A PATIENT OF:

☐ Dr. Restifo	☐ Dr. Yau	☐ Dr. Saleh
☐ Dr. Chester	☐ Dr. Hansen	☐ Dr. Parker
☐ Dr. Klein	☐ Dr. McBride	☐ Dr. Ackerly
☐ Dr. Umhau	☐ Dr. Dooley	☐ Dr. Delistathis

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?
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 3/22