FOXHALL UROLOGY

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Name _____ ☐ M ☐ F Social Security Number _____

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Date of Birth _____ HT___ WT___ Marital Status _____

Employer _____ Position _____

Employer's Address _____ Work Phone _____

Name of ☐ Spouse or ☐ Parent (please check one) _____

Address _____ Home Phone _____

Employer _____

Address _____ Work Phone _____

Who referred you to our group? _____

Has any family member been a patient here before? If so, who? _____

Please list any know drug allergies _____

Current medication _____

Pharmacy _____ Phone _____

Emergency contact, other than the person with whom you live _____ Phone _____

BILLING INFORMATION

Primary Insurance:

Insurance Company Name _____

Address _____

Policy No. _____

Group No. _____

Subscriber Name _____

Relationship to Patient _____

Secondary Insurance:

Insurance Company Name _____

Address _____

Policy No. _____

Group No. _____

Subscriber Name _____

Relationship to Patient _____

PATIENT AUTHORIZATION

I accept full responsibility for knowing the terms and conditions of my insurance coverage as Foxhall Urology does not participate with any insurance programs. I also accept full responsibility for payment at the time of visit for services rendered up until and including this date, regardless of my insurance coverage. I authorize the release of my medical records for insurance purposes and I agree to assign benefits received for services by this practice to the physicians.

_____ _____

Signature Date