Foxhall Pediatrics

3301 New Mexico Avenue, NW
Washington, DC 20016
Ph: 202 537 1180
Fax: 202 244 7410
Email: doctors@foxhallpediatrics.com

PATIENT REGISTRATION - *Please print clearly*

PATIENTT NAME (LAST, FIRST MIDDLE)		DATE OF BIRTH	GENDER	AGE
HOME ADDRESS	APT NO	CITY	ST	ZIP CODE
MOTHER/GUARDIAN NAME		EMPLOYER	PRIMARY PHONE	
MOTHER/GUARDIAN ADDRESS		WORK PHONE	CELL PHONE	
MOTHER'S EMAIL ADDRESS		FATHER EMAIL'S ADDRESS		
FATHER/ GUARDIAN NAME		EMPLOYER	PRIMARY PHONE	
FATHER/GUARDIAN ADDRESS		WORK PHONE	CELL PHONE	
EMERGENCY CONTACT		RELATIONSHIP	PRIMARY PHONE	
EMERGENCY CONTACT ADDRESS			CELL PHONE	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is that payment is to be made at the time services are rendered. Whether or not your Insurance company pays in full, a portion, or no portion of your medical bill, is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of visit. Payment is accepted in the form of cash, check, MasterCard or Visa. Preferred method of payment is either cash or check.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

X_______________________________________

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME	LAST NAME	SSN	RELATIONSHIP TO PATIENT	
	HOME ADDRESS		CITY	ST	ZIP CODE
	EMPLOYER		WORK PHONE	HOME PHONE	
PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE	
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SSN	DATE EFFECTIVE	
	SUBSCRIBER'S NAME	SEX	HOME PHONE	WORK PHONE	
	SUBSCRIBER'S ADDRESS		SUBCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT	

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