National Center for Advanced Pelvic Surgery

106 Irving Street, NW, Suite 405 South, Washington, DC 20010-2975

MedStar Washington Hospital Center

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy City: _____ Pharmacy Located in What State: _____

Patient Name (please print): _____
first middle last

DOB: _____ Sex: _____ SS# _____

Home/Billing Address: _____
street city state zip code

Phone #'s: _____
home work cell

Occupation: _____ If Retired (month/year): _____
employer & address

Emergency Contact/Relationship: _____ Phone #: _____

Primary Insurance

Name: _____ Policy #: _____ Group# _____

Subscriber's Name (please print): _____
If different from above Relationship to subscriber

Subscriber's DOB: _____ Subscriber's Employer: _____

Secondary Insurance

Name: _____ Policy #: _____ Group# _____

Subscriber's Name (please print): _____
If different from above Relationship to subscriber

Subscriber's DOB: _____ Subscriber's Employer: _____

Physician Information

Primary Care Dr.: _____ Phone #: _____

Address: _____
street city state zip

Referring Dr.: _____ Phone #: _____

Address: _____
street city state zip

I, the undersigned certify that the above information is correct and true. I further authorize the release of any medical information necessary to obtain reimbursement from the insurance carrier(s) listed. For those insurers which the MedStar Washington Hospital Center accepts assignment, I understand that I am responsible for all co-payments, deductibles, and non-covered services by my insurance company. I further understand that receiving care at the MedStar Washington Hospital Center location may result in a hospital facility charge as well as a professional charge for outpatient services and/or procedure.

Signed: _____ Date: _____

Rev: 2/12