900 17TH ST NW Suite 300
Washington, DC 20006
Phone: (202) 659-2223
Fax: (202) 659-0289

Patient Information

Date: _____ Birth Date: _____ Name: _____

Gender: _____ Preferred Pronoun(s):_____

Email Address: _____ Marital Status: M _D_W_S_P_

Street:_____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Employer/Occupation:_____ Phone:_____

Personal Physician:_____ Referring Physician:_____

Person Responsible for Bill:_____ Relationship:_____

Address:_____ Phone:_____

Allergies:_____ Have you ever had Hepatitis? Y__N__

Please list all current medical conditions:

1. 3.

2. 4.

Please list all current medications: 1. 2.

3. 4.

INSURANCE INFORMATION:

Company_____ ID Number_____ Group Number_____

Company_____ ID Number_____ Group Number_____

My Relationship to Insured: Self__ Spouse__ Child__ Other__

If insurance is in someone else's name, please fill in:

Name of Insured_____ DOB_____

Address_____ Phone_____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Edward H. Stolar, MD, PC and Todd E. Perkins, MD, for services provided. I agree to pay Edward H. Stolar, MD, PC and Todd E. Perkins, MD, all co-payments, coinsurance, deductibles, and any non-covered services as stipulated under my insurance plan. Non-covered services include cosmetic procedures not medically necessary and any service that has not been authorized by my insurance company. **I understand that there will be a $50 charge for missed office visits and $100 charge for missed surgical appointments if notice is not given a full business day before the appointment.**

Signed_____ **Date**_____