RONDI KATHLEEN WALKER, M.D.
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SUITE 252
WASHINGTON, D.C. 20016

PATIENT INFORMATION

NAME: ____

ADDRESS: ____

CITY ____________________________ STATE __________ ZIP ____________

SOCIAL SECURITY NUMBER OF PATIENT ____-___-____ EMAIL ____________

HOME PHONE ( )_______________ WORK PHONE ( )__________________

SEX____ AGE____ DATE OF BIRTH____/____/_____ MARITAL STATUS__________

EMPLOYER ___________________________ STUDENT: YES OR NO

EMERGENCY REFERENCE __________________ PHONE #: ____________________

REFERRED BY ______________________________

PARTY RESPONSIBLE FOR PAYMENT ______________________________________

BILLING ADDRESS (if different from above)____________________________________
____

SOCIAL SECURITY NUMBER OF RESPONSIBLE PARTY _________________________

MEDICAL INSURANCE INFORMATION:

PRIMARY__________________________________ ID#:_____________________

SECONDARY_______________________________ ID#:_____________________

Payment is expected at the time of your visit. Payment is the responsibility of the patient.
We will provide the necessary insurance forms to the patient so that he or she can forward them to an insurance company for reimbursement.
Your account may be sent to collections for any part that is unpaid. Should this occur, you will be responsible for any attorney's fees and interest incurred in the collection of this account, as well as any other reasonable costs including clinician's expenses and fees for court appearances.

DATE: ________________ SIGNATURE ______________________________________