

THE NADERI CENTER

297 Herndon Pkwy, Suite 101, Herndon, VA 20170

703.481.0002

5454 Wisconsin Ave, Suite 1710, Chevy Chase, MD 20815

301.244.0150

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

Last

First

Middle

Address

Street & Apt #

City

State

Zip

Home Phone

Cell Phone

Work Phone

Any restrictions for contacting you? No Yes**E-mail**

Contact

Drivers License #

Restrictions:

(include State)

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female MaleMarital Status Single Married to: _____ Other: _____**Patient's Employer**

Occupation

Work Phone

Ext: _____

Is it okay to call you at work? Yes No

Address

Street & Suite #

City

State

Zip

Emergency Contact

Relationship to Patient

Home Phone

Work Phone

Other Phone

Address

Street & Apt #

City

State

Zip

Primary Health Insurance Company

Policy #

Group #

Ins. Phone

Referral Required? No YesCopay? No Yes, \$ _____**Insured:** Name

DOB

Employer

Secondary Health Insurance Company

Policy #

Group #

Ins. Phone

Referral Required? No YesCopay? No Yes, \$ _____**Insured:** Name

DOB

Employer

I understand **purely cosmetic consultations** carry a \$240 fee that may be applied towards my surgery or procedure. I realize there is a "no show" fee of \$85 if I do not cancel or reschedule at least 24 hours ahead of time. All other consultations will be billed to me &/or my insurance company. I understand that office visit charges are payable in full on the *same day service is rendered*. All payments for surgery are due at least 2 weeks in advance of surgery. If insurance can pay for part of my desired surgery then my insurance may be charged for the office visit(s). I authorize The Naderi Center to bill my insurance company when appropriate. Regardless of insurance coverage, **I am responsible for all bills being paid in full in a timely manner**. I understand that my contract is between The Naderi Center and myself and it is my responsibility to follow through with my insurance.

Signature**Date****E-mail**

Please make sure the information and spelling is completely accurate. It is your responsibility to keep this information up to date and inform us of any changes in the future