ANNAPOLIS DERMATOLOGY CENTER

71 OLD MILL BOTTOM ROAD, NORTH, SUITE 300
ANNAPOLIS, MD 21409
PH (410) 268-3887 FAX (410) 268-8171

PATIENT INFORMATION

FIRST NAME _____MI _____ LAST NAME _____

STREET ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

PHONES: HOME_____WORK_____ CELL _____

SEX _____ DATE OF BIRTH _____ SSN _____ SPOUSE'S NAME _____

E-MAIL ADDRESS _____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _____ EFFECTIVE DATE _____

POLICY HOLDER _____ POLICY/ID NUMBER _____

GUARANTOR NAME IF PATIENT IS UNDER 21 _____DATE OF BIRTH _____

GROUP NUMBER _____ COPAY ____5____10____12____15____20____25____30____ OTHER ____
AMOUNT

EMPLOYER NAME_____ EMPLOYER ADDRESS _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _____ EFFECTIVE DATE _____

POLICY HOLDER _____ POLICY/ID NUMBER _____

GUARANTOR NAME IF PATIENT IS UNDER 21 _____ DATE OF BIRTH _____

GROUP NUMBER _____COPAY ____5____10____12____15____20____25____30____OTHER ____
AMOUNT

EMPLOYER NAME_____ EMPLOYER ADDRESS _____

MEDICAL INFORMATION

PLEASE LIST ANY PAST/CURRENT MEDICAL HISTORY:

_____

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ____YES____NO

PLEASE LIST IF ANY: _____

FAMILY PHYSICIAN: _____PHONE NUMBER _____

PHARMACY NAME: _____PHONE NUMBER _____

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*I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION INCLUDING INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS OR ANY MEDICAL INFORMATION THAT IS NEEDED FOR UTILIZATION REVIEW OR QUALITY ASSURANCE ACTIVITY. I ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED TO *ANNAPOLIS DERMATOLOGY CENTER, P.A.*, THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL. ** ***I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR A $25.00 FEE FOR A REGULAR OFFICE APPOINTMENT, AND A $50.00 FEE FOR ANY COSMETIC OR SURGICAL EXCISION APPOINTMENT NOT KEPT NOR CANCELED WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT, THIS INCLUDES CANCELLATIONS MADE THE SAME DAY AS THE SCHEDULED APPOINTMENT***. ***I FURTHER UNDERSTAND THAT I WILL NEED TO RESCHEDULE MY APPOINTMENT IF NO REFERRAL OR VALID INSURANCE INFORMATION (CARD) IS PRESENTED AT THE TIME OF SERVICE.

_____ _____ _____
PATIENT/PERSON GIVING CONSENT RELATIONSHIP, IF NOT PATIENT DATE

I AUTHORIZE THE PHYSICIAN TO GIVE ANY RESULTS TO MY SPOUSE _____

(BELOW FOR OFFICE USE ONLY)

HIPAA PRIVACY CONSENT SIGNED Y N DATE SIGNED ____/____/____ INITIALS _____

PT INFORMATION VERIFIED AS CURRENT BY: (PLEASE INITIAL)

UPDATED/YR____/_____UPDATED/YR____/_____ UPDATED/YR____/_____UPDATED/YR____/_____UPDATED/YR___/_____