Drs Ford & Rothman, Cosmetic and Clinical Dermatology, LLC
6 MONTGOMERY VILLAGE AVENUE, GAITHERSBURG, MD 20879
PHONE: 301-977-2070 * FAX: 301-330-9452

PATIENT INFORMATION ___ New Patient___Name Change___Address Change___Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Name_____
Last First M.I.
Date of Birth: ____/____/____ Age: _____ Social Security #_____ Sex: M or F

ADDRESS:

Mailing Address _____
City State Zip
Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ E-mail: _____

Marital Status: ___ Single___ Married___ Divorced___ Widowed___ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ____/____/____
Last First M.I.

Address:_____
City State Zip
Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:_____ Phone: ( )_____ Ext:_____

Address of Claim Center:_____
City State Zip Code
Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____ SS#_____ Sex: M or F

Policy #:_____ Group #:_____Policy Type:____ HMO____ PPO

Employer Name: _____

Employer Address: _____

If patient is child, check relationship: ____Mother ____ Father ____Other_____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____ Phone: ( )_____ Ext:_____

Address of Claim Center:_____
City State Zip Code
Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ____/____/____ SS#_____ Sex: M or F

Policy #:_____ Group #:_____Policy Type:____ HMO____ PPO

Employer Name: _____

Employer Address: _____

If patient is child, check relationship: ____Mother ____ Father ____Other_____

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REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_____ Today's Date ____/____/____

Other family members that are patients: _____
Referred by: _____

Primary Care Physician: _____ Phone: ( )_____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified?_____

Relationship:_____Phone:( )_____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____)_____Phone # (evening): (_____)_____

May we leave personal medical information on your answering machine?

Home Y or N Cell Y or N Work Y or N

#_____ #_____ #_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES: My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.
Patient or Responsible Party Signature_____ Date ____/____/____

PAYMENT POLICY:
HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered services and/or cosmetic services.
Patient or Responsible Party Signature _____ Date____/____/____