PATIENT INFORMATION RECORD

ANNE ARUNDEL DERMATOLOGY, P.A.

PATIENT ACCOUNT NO.

Please PRINT All Information

PATIENT INFORMATION **DATE**

PATIENT'S NAME (LAST, FIRST, MI)			SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL or ALTERNATE PHONE	
EMAIL ADDRESS:			

SEX	MARITAL STATUS	AGE	DATE OF BIRTH	HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE:
☐ Male ☐ Female	☐ Married ☐ Single ☐ Legally Separated ☐ Divorced ☐ Unknown ☐ Widowed			☐ Yes ☐ No IF YES, WHEN?

OCCUPATION	EMPLOYER
WORK ADDRESS	IS CONDITION WORK RELATED?
SPOUSE'S NAME(LAST, FIRST, MI)	SPOUSE'S DATE OF BIRTH

STUDENT STATUS	PRIMARY CARE PHYSICIAN	ADDRESS	PHONE
☐ Full Time ☐ Part Time ☐ Not A Student			

I AUTHORIZE ANNE ARUNDEL DERMATOLOGY, P.A. TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO THE PARTIES LISTED BELOW

NAME	NAME
RELATIONSHIP	RELATIONSHIP
CONTACT NUMBER	CONTACT NUMBER

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME		RELATIONSHIP
ADDRESS		
OCCUPATION	EMPLOYER	PHONE
ADDRESS		WORK PHONE

POLICY HOLDER INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER	
GROUP #	CERTIFICATE / POLICY / ID#	POLICY HOLDERS DATE OF BIRTH
MEDICARE #	MEDICAID #	POLICY HOLDER'S SOCIAL SECURITY NUIMBER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER	POLICY HOLDER'S SOCIAL SECURITY NUIMBER
GROUP #	CERTIFICATE / POLICY / ID #	POLICY HOLDERS DATE OF BIRTH

MEDICARE/MEDIGAP AUTHORIZATION

"I request that payment of authorized Medicare/Medigap benefits be made directly to ANNE ARUNDEL DERMATOLOGY, P.A. for any services furnished me by that physician supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents, or any other insurance carrier (_____), any information needed to determine these benefits payable for related services."

Signed _____ Date _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

"I authorize ANNE ARUNDEL DERMATOLOGY, P.A. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance."

Signed _____ Date _____

*** A fee may be incurred for No Show and/or cancellations without required notice. Initial _____ Date_____ ***

How did you hear about Anne Arundel Dermatology, P.A.

☐ **TV** ☐ **Radio** ☐ **Newspaper** ☐ **Magazine** ☐ **Internet** ☐ **Family / Friend** ☐ **Other:** _____