Anne Arundel DERMATOLOGY
and Affiliate Practices

PATIENT ACCOUNT NO.

Patient Information Record
Please PRINT All Information

DATE

PATIENT INFORMATION

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

SEX	MARTIAL 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	
SPOUSES NAME (LAST, FIRST, MI)	SPOUSES DATE OF BIRTH

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

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 #	

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	NAME OF POLICY HOLDER	POLICY HOLDERS DATE OF BIRTH
GROUP #	CERTIFICATE / POLICY / ID #	

Assignment of Benefits:

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/ or all commercial payors to make payments on my behalf directly to Anne Arundel Dermatology. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

Signed _____ Date _____

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

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

☐ Radio ☐ Insurance Website ☐ Magazine ☐ Google Search ☐ Social Media ☐ Family/Friend ☐ Physician Referral ☐ Other: _____