

DR. ERIC FINZI & ASSOCIATES  
*General & Cosmetic Dermatology*

Chevy Chase Cosmetic Center • 240-482-2555 | Dermatology & Cosmetic Surgery Associates • 301-345-7375

**PATIENT REGISTRATION FORM**

Please print clearly ☺

Patient: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ Today's Date: \_\_/\_\_/\_\_

Patient's Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_ Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Guardian if Patient is a Minor: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt./Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Personal Email Address: \_\_\_\_\_

\*Would you like to receive periodic practice E-News, Events & Special Promotions? Yes \_\_\_\_\_ No \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: M S D W (circle one) Student Status: F/T P/T (circle one)

Employment Status: F/T P/T Self Retired Unemployed Military Active Duty (circle one)

Patient Employment Information:

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**INSURANCE COMPANIES REQUIRE THAT PATIENT INFORMATION BE SUBMITTED ANNUALLY**

**INSURANCE INFORMATION:**

**PRIMARY**

**SECONDARY**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: \_\_\_\_\_

ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_

Policy Holder's SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

**Please print clearly ☺**

**Person Financially Responsible for Account** – Self Spouse Patient Legal Guardian (circle one)

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Driver's License#: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

**How Did You Hear About Us? (circle one)**

Referring Physician Insurance Plan Family/Friend Internet/Website Yellow Pages

Advertisement: \_\_\_\_\_ Other: \_\_\_\_\_

Do we have permission to:

Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your medical with any member of your family?	Yes	No
If yes, with whom? _____	Relationship: _____	

Preferred number to call regarding lab results/appointments: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### MEDICAL HISTORY FORM

Patient: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_ Today's Date: \_\_/\_\_/\_\_  
 (Last name, First, Middle Initial)

Reason for today's visit: \_\_\_\_\_

Do you currently have or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b>	<b>YES</b>	<b>NO</b>	<b>Other Systemic:</b>	<b>YES</b>	<b>NO</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	<b>YES</b>	<b>NO</b>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological Disorders</b>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of Veins	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	HIV+	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
			Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases, chronic conditions, or surgical procedures performed in the last 6 months:

\_\_\_\_\_

**Skin:** **if yes, please specify:**

Have you ever had skin cancer?  YES  NO \_\_\_\_\_

Has anyone in your family had skin cancer?  YES  NO \_\_\_\_\_

Do you have a history of any specific skin diseases?  YES  NO \_\_\_\_\_

Do you have problems with healing  YES  NO

Do you develop keloids (scars) after surgery  YES  NO

Do you bleed easily?  YES  NO

Do you develop skin rashes in reaction to:

Medications  Food  Environment  Bandages  Topical  Neosporin  Other \_\_\_\_\_

**Social History:**

Do you drink alcohol?  YES  NO If Yes, number of drinks per day \_\_\_\_\_

Do you smoke?  YES  NO If Yes, number of cigarettes per day: \_\_\_\_\_

Ladies, are you pregnant or breast feeding?  YES  NO

Completed by: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

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## Payment Consent and Policies

**INSURANCE ASSIGNMENT:** If you have insurance, a claim for reimbursement for services rendered today will be submitted based on the information you provided to Dermatology & Cosmetic Surgery Associates and/or the Chevy Chase Cosmetic Center, ("Practice"). I agree to authorize and assign insurance payments for such services to the Practice, and authorize the release of private health information for treatment, reimbursement and billing purposes. I understand that it is my responsibility to pay for non-covered services, co-insurances, co-payments and deductibles on the day services are rendered. I understand that the Practice will rely on the insurance information you provide on the day of your visit to submit a claim for reimbursement and additional laboratory tests if necessary. The Practice will not resubmit your claim due to incomplete or incorrect insurance information. If the Practice has not received payment within 60 days of your date of service, all charges will become your financial responsibility and will be due immediately, payable by you, including but not limited to all charges for laboratory testing associated with your visit.

**MEDICARE:** This consent authorizes the release of your health information to the Social Security Administration and the Healthcare Finance Administration or its intermediaries or carriers, any information needed for this and related Medicare claims. I authorize and assign insurance payments directly to the Practice for services rendered. I understand that I am responsible for any health insurance deductibles, co-payments and non-covered services and/or procedures.

**SELF-PAY PATIENTS:** If you do not have health insurance coverage, payment is due in full for all services and/or procedure rendered on the day of service. If laboratory services are required, you will be billed directly from the laboratory company.

**CANCELLATION POLICIES FOR COSMETIC APPOINTMENTS:** Due to the amount of time reserved for a procedure, all cosmetic services require a 50% deposit to be paid at the time the appointment is scheduled and the balance is due on the day of the procedure prior to services rendered. A 48 hour cancellation notice is required by the patient for all cosmetic appointments in order to receive a full refund of your deposit. If you cancel your appointment within a 24 hour notice, 50% of your deposit will be forfeited and 50% will be remitted to you. If you cancel or reschedule your appointment with less than a 24 hour notice, you will forfeit 100% of your deposit. In the event you do not show up for your appointment, you forfeit 100% of your deposit.

**CANCELLATION POLICY FOR GENERAL DERMATOLOGY APPOINTMENTS:** We require a 24-hour notice if you cancel or reschedule a general dermatology appointment. A fee of \$25.00 will be charged for appointments not cancelled or rescheduled 24 hours in advance.

**BALANCE DUE:** Outstanding balances due over 30 days will be assigned a monthly late fee of 1.5% of your balance. If the balance is referred to an agency or attorney for collection, you agree to pay all attorneys' fees.

This agreement is valid for all services and procedures rendered by all providers associated with Dermatology & Cosmetic Surgery Associates and Chevy Chase Cosmetic Center. By signing below as the patient, parent, legal guardian and/or responsible party (for minors, the responsible party is the person who has legal custody of the minor) you consent to the services rendered and agree to make all required payments as indicated above. You permit a copy of this agreement to be used in place of the original.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_