GEORGETOWN
DERMATOLOGY

PLEASE GIVE THE RECEPTIONIST
YOUR **PHOTO ID** AND CURRENT **INSURANCE CARD**(S)

PATIENT INFORMATION: **TODAY'S DATE:**______________

NAME____
LAST FIRST MIDDLE

SEX________DOB____________________PATIENT'S SSN#________--______--________
MM DD YYYY

Address:___________________________________City:____________________State:________

Zip Code:__________Home phone: (__)______________E-mail Address:__________________

Employer:____

Work phone: (__)____________________________Cell phone: (__)______________________

Primary Care Physician:____

Referring Physician:____

SPOUSE INFORMATION: (Parent/Guardian, if applicable):

NAME ____
LAST FIRST MIDDLE
Address:______________________________City:____________________State:______________

Zip Code:______________Home phone: (__)____________________E-mail Address:______________________

Work phone: (__)__________________________Cell phone: (__)______________________________

PRIMARY INSURANCE INFORMATION:

Insurance Co. Name:__________________________________Phone No.:______________________

Address, City, State & Zip Code: ____

Policy ID#:_________________________________Group #:_______________________________

Subscriber Name:________________________________Relationship to Patient:_____________________

Subscriber DOB:____________/______/______ **Subscriber** SSN:______________________________
MM DD YYYY
Does your plan require **referral**?________________**Co-pay** Amount: $__________________________

3301 New Mexico Avenue, NW Suite 210, Washington, DC 20016
Phone 202.363.9600 FAX 202.363.9601

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SECONDARY INSURANCE INFORMATION:

Insurance Co. Name:______________________________________Phone No.:__________________________

Address, City, State & Zip Code: ____

Policy ID#:______________________________________Group #:__________________________________

Subscriber Name:__________________________________Relationship to Patient:_________________

Subscriber DOB:_____________/_______/_______ **Subscriber** SSN:_____________________________

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

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

☐ Yes ☐ No (If yes, please provide their name and phone number below):

Name:____Relationship:______________________________

Phone (Day):____________________________________Phone (Evening):__________________________

EMERGENCY CONTACT INFORMATION:

In case of emergency, whom should we notify?

Name:____Relationship:______________________________

Phone (Day):____________________________________Phone (Evening):____________________

I certify that the information that I have reported with regard to my insurance coverage is accurate and current. I understand that my protected health information will necessarily be released in order to apply for these insurance benefits – i.e., to be used in treatment, payment activities and healthcare operations.

I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier(s). A copy of this authorization may be used in place of the original.

I understand that I may revoke this consent at **any time** with written notice to GEORGETOWN DERMATOLOGY, PLLC.

Protected Health Information (including billing information) may be released to the following individual(s):

____

I understand that I have the right to inspect and obtain copies of protected healthcare information (in accordance with federal privacy regulations 45 CFR 164.524).
I understand that I do not have to sign this consent and that my refusal to sign will not affect my eligibility for benefits.
I have the right to obtain a copy of this form.

Patient Signature (Parent/Guardian, if Applicable):____

Today's Date: ______/______/______