CHEVY CHASE DERMATOLOGY CENTER

PAIENT INFORMATION

First Name	Middle Initial	Last Name	
Street Address	City	State	Zipcode
Home Phone#	Work Phone#	Cell Phone #	
Birthdate	Age	Sex (circle one) F M	Race	Martial Status	Spouse's Name
Email Address	Preferred Phone Number		

RESPONSIBLE PARTY OR INSURANCE POLICY HOLDER (IF OTHER THAN PATIENT)

Policy Holder's First Name	Policy Holder's Middle Initial	Policy Holder's Last Name	
Street Address	City	State	Zip Code
Policy Holder's Home#	Policy Holder's Work #	Policy Holder's Cell#	Policy Holder's Date of Birth
Who may we thank for referring you to our office?	Please tell us the name of your primary /referring physician?		

PLEASE READ AND CHECK THE BOXES BELOW:

☐ I understand this office ONLY participates with Medicare Part B insurance and I will be responsible for today's services if I do not have Medicare Part B insurance as my PRIMARY INSURANCE.

☐ I understand that if payment is required, it is due at the time of service and this office ONLY accepts VISA, AMEX, MASTERCARD, DISCOVER, and EXACT cash.

PLEASE NOTE: For ALL scheduled appointments in which notification of cancellation is not received at least 24 hours prior to your appointment time, you WILL BE charged a fee of **$75.00**. For surgical and cosmetic appointments, this fee increases to **$200** due to the length of time set aside for these appointments. Exceptions will be made only in the case of an emergency and at the discretion of the Doctor/Manager. Please sign below as acknowledgment of the above policies.

PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT: VISA, MASTERCARD, DISCOVER, AMEX OR EXACT CASH

Signature_____ **Date:** _____