PATIENT ACCOUNT #:

DR. ERIC FINZI & ASSOCIATES
General & Cosmetic Dermatology

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

Eric Finzi, MD, PhD
Ronald A. Katz, MD
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Allison Wagner, PA-C
Mariella Purvis, PA-C

PLEASE PRINT

PATIENT NAME: (LAST, FIRST, M)		SOCIAL SECURITY NO:	TODAY'S DATE:
PATIENT'S SEX: MALE: ☐ FEMALE: ☐	DATE OF BIRTH:	PRIMARY CARE DOCTOR:	PCP TELEPHONE NUMBER:
PATIENT'S STREET ADDRESS:			APT/BUILDING NO:
CITY:		STATE:	ZIPCODE:
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ N/A	STUDENT STATUS: ☐ Full-time ☐ Part-time ☐ N/A	EMPLOYMENT STATUS: ☐ Full-time ☐ Part-time ☐ Self ☐ Retired ☐ Unemployed ☐ Military-Active Duty	
OCCUPATION:	EMPLOYER NAME:	CITY, STATE:	
REFERRED BY:	PHARMACY NAME:	PHARMACY TELEPHONE NO.:	

EMAIL ADDRESS:	**Would you like to receive periodic practice E-News, Events & Special Promotions?** ☐ YES ☐ NO

PLEASE SELECT THE TELPHONE NUMBER(S) WE MAY CALL CONCERNING THE PATIENT'S CONDITION, LAB RESULTS, ETC: ☐ Home ☐ Cell ☐ Work ☐ Other _____	**CAN WE LEAVE A DETAILED MESSAGE OR ONLY A CALL BACK NUMBER?:** ☐ Leave a detailed message ☐ Only leave a call back number ☐ Other _____	**CAN WE DISCUSS YOUR MEDICAL CONDITION OR ACCOUNT WITH FAMILY / A FRIEND?** ☐ Yes ☐ No
IF YES, WHO CAN WE DISCUSS YOUR CONDITION / ACCOUNT WITH?:	**RELATIONSHIP TO PATIENT:**	

PRIMARY INSURANCE INFORMATION ☐ **CHECK HERE IF YOU DO NOT HAVE INSURANCE**

INSURANCE COMPANY NAME:	NAME OF POLICY HOLDER:	
POLICY HOLDER'S RELATIONSHIP TO PATIENT:	POLICY HOLDER'S SOCIAL SECURITY NUMBER:	POLICY HOLDER'S DATE OF BIRTH:
INSURANCE POLICY/ ID NUMBER:	INSURANCE GROUP NUMBER:	SPECIALIST COPAY AMOUNT:

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:	NAME OF POLICY HOLDER:	
POLICY HOLDER'S RELATIONSHIP TO PATIENT:	POLICY HOLDER'S SOCIAL SECURITY NUMBER:	POLICY HOLDER'S DATE OF BIRTH:
INSURANCE POLICY/ ID NUMBER:	INSURANCE GROUP NUMBER:	SPECIALIST COPAY AMOUNT:

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (IF OTHER THAN PATIENT)

NAME:	RELATIONSHIP:		
MAILING ADDRESS:	APT/BUILDING NO.:	CITY, STATE:	ZIPCODE:

PATIENT / RESPONSIBLE PARTY SIGNATURE: **X**	**DATE:** **X**