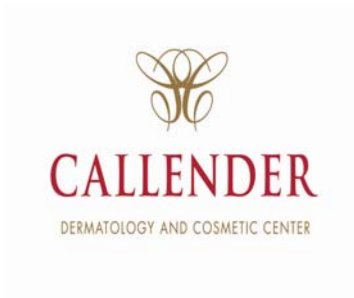

MEDICAL HISTORY

Name:________________________________ Date:______________

Age_________ Ethnicity/Race___________ Male/Female______ Pregnant___
(Optional) (yes/no)

Medical Illness (es)____
____

Current Medication (s)____
____

Current Dermatology Medication (s)____
____

Past Dermatology Medication (s)____
____

Medication Allergies____

Skin/Hair/Nail Concerns: (example: skin rash on arm, hair loss, acne)

1. ____

2. ____

3. ____

Valerie D. Callender, M.D.
Medical Director

PATIENT INFORMATION

Name:____Date of Birth:_________________________

SS#:____Married/Single__________M/F___________

Home Address:______________________________________City:________________________________

State/Zip:_________________________________Home Phone:________________________________

Work Phone:________________________________Cell Phone:_________________________________

Email Address:____

Employer's Name:____

Address:____

Primary Doctor:____

INSURANCE INFORMATION: IF YOUR INSURANCE REQUIRES THAT YOU BRING IN A REFERRAL, IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH A VALID REFERRAL FOR YOUR VISITS. PLEASE CHECK THE EXPIRATION DATE. PLEASE BE SURE TO GIVE YOUR DRIVER'S LICENSE & INSURANCE CARDS TO THE RECEPTIONIST.

Policy Holder: ( )Self ( )Spouse( ) Parent Name:____

SS#:_________________________________D.O.B.____

Primary Insurance:____

ID Number:____Group Number:________________________

Address:____

Secondary Insurance:____

ID Number:_________________________________Group Number:_______________________________

Policy Holder:_____________________________SS#:__________________D.O.B.________________

I ACKNOWLEDGE THE ABOVE INFORMATION IS ACCURATE AND AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO PROCESS ANY CLAIMS THROUGH MY HEALTH INSURANCE.

SIGNATURE:____DATE:__________________

PATIENT PRIVACY & PRACTICE POLICIES (PLEASE INITIAL ALL ITEMS BELOW)

PATIENT PRIVACY POLICY: I have reviewed a copy of the practice privacy policies. I understand that the practice may change this privacy policy in the future. _________ Initials

MEDICAL POLICY: I understand that this office employs University Trained board certified **PHYSICIAN ASSISTANTS** and that they may be involved in rendering portions of my medical care along with an attending physician. __________ Initials

MEDICAL RECORDS RELEASE POLICY: The practice requires a minimum $25.00 fee for researching, copying and to mail medical record (if applicable). This fee is based upon the size of the medical record and is due in full prior to their release. _______ Initials

FINANCIAL POLICY: We are dedicated to providing you with the best possible care and service. Your understanding of our financial policies is an essential element of your care and treatment. To assist you, we have the following financial policy. Unless either you or your health coverage carrier has made other arrangements in advance, full payment is due at the time of service. For your convenience we accept cash, checks (minimum $20.00), Visa, MasterCard and American Express. If you have any questions please feel free to discuss them with our staff. _________ Initials

INSURANCE POLICY: We have made prior arrangements with many insurance health plans. We will bill those plans with which we have an agreement and will collect co-pays and/or a deductible at the time of service when you arrive for your appointment. In the event your health plan determines a service to be non-covered, you will be responsible for the complete charge. Subsequently, we will bill you directly and payment is due upon receipt of the statement. We will also bill your health plan for all services we provide in the hospital. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. _________ Initials

CANCELLATION POLICY: To avoid a fee of $25.00 or $50.00 (surgery apt.), please do the following:

*Allow 24 hours advance notice when canceling a follow up appointment (return office apt.) _________ Initials

*Allow 48 hours advance notice when canceling a surgery appointment. __________ Initials

To avoid a cancellation fee of $50.00 please allow 48 hours advance notice when canceling a weekend (Saturday) surgery appointment. __________ Initials

FOR YOUR CONVENIENCE, PLEASE FEEL FREE TO VISIT OUR WEBSITE at www.CallenderSkin.com TO RESCHEDULE/CANCEL YOUR APPOINTMENT (CONTACT US PAGE).

I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.

____ ____

SIGNATURE OF PATIENT/PARENT PRINT NAME OF POLICY HOLDER

____ ____

PRINT NAME OF PATIENT (MINOR) DATE

CALLENDER

DERMATOLOGY AND COSMETIC CENTER

FAIRWOOD OFFICE PARK
12200 Annapolis Road, Suite 315
Glenn Dale, MD 20769
301-249-0970 Telephone
301-249-4246 Fax

PHARMACY FORM

This form is helpful information in the electronic transmission of your prescription directly to the pharmacist.

Patient Name____________________________________

Pharmacy Name _________________________________

Address ____

Phone Number __________________________________