DAVID GREEN, M.D. BETHESDA

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(301) 907-7250 ● Fax: (301) 907-7234 ● www.LaserDerm.net

COSMETIC & LASER CENTER OF ANNAPOLIS

24 Defense Street ● Annapolis, MD 21401
(410)974-6444 ● Fax: (410) 974-6873 ● www.AnnapolisCosmeticCenter.com

## DERMATOLOGY REGISTRATION

**Date:** ___/___/____ **How were you referred?** Internet □ Physician□ Patient□ Other: ____________________

**Name of referring physician: Dr.** ____________________ **Name of primary care physician: Dr.** ____________________

## GENERAL INFORMATION

First Name: ____________________ M.I.: ______ Last Name: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: __________

Age:____ Date of Birth: ___/___/___ LAST 4 of SS#: ________ Marital Status: __________ Spouse's Name: ______________

Occupation: ____________________ Employer: ____________________

Employer Address: ____________________

Telephone **Home:** (     )          -           **Business:** (     )          -           **Cell:** (     )          -

Contact number during work hours: Home□ Business□ Cell□ Contact number after work hours: Home□ Business□ Cell□

Emergency Contact: Name: ____________________ Phone: (     )          -           Relationship__________

**E-MAIL:**____________________ YES / NO Please register me for email updates *(we do NOT share email addresses with other businesses)*

## MEDICAL INFORMATION

Circle: Male / Female Height: __________ Weight: __________

Reason for current visit: ____________________ Duration of this problem: ____________________

Current treatment, if any: ____________________

Is this a new problem? YES / NO If No, past treatments: ____________________

Other current skin disorders: ____________________

Previous skin disorders: ____________________

Family skin disorders: ____________________

Are you prone to scarring? YES / NO If YES, provide details: ____________________

Are you prone to brown patches after minor injuries? YES / NO If YES, provide details: ____________________

Are you prone to bruising? YES / NO If YES, provide details: ____________________

Current medical problems: ____________________

Past medical problems: ____________________

Current medication (prescription and OTC): ____________________

**ALLERGIES to medications**: ____________________

Do you smoke cigarettes? YES / NO If YES, provide details (# of years, packs per day): ____________________

Have you ever been tested for hepatitis? YES / NO If YES, provide details: ____________________

Have you ever been tested for HIV? YES / NO If YES, provide details: ____________________

Are you prone to lightheadedness or fainting? YES / NO If YES, provide details: ____________________

**COSMETIC INTEREST** ***(optional) - Please check additional interests***

| | | | |
|---|---|---|---|
| ☐ BOTOX® Cosmetic | ☐ VANQUISH Fat Removal | ☐ THERMAGE CPT | ☐ VEIN TREATMENTS |
| ☐ BOTOX® for Under Arm Sweat | ☐ IPL PHOTO-FACIALS | ☐ TATTOO REMOVAL | ☐ ENDOVENOUS ABLATION |
| ☐ JUVEDERM XC | ☐ SKIN CARE & PRODUCTS | ☐ SKIN CANCER SCREENING | ☐ MICRO-NEEDLING |
| ☐ VOLUMA XC | ☐ FACIALS | ☐ PEELS | ☐ MICRODERMABRASION |

**MEDICAL INSURANCE INFORMATION**

**I authorize the release of any medical information that may be requested by my insurance carrier. _____**
**Name of insurance carrier**: ________________________________________________________________

**PRIMARY INSURANCE HOLDER INFORMATION**
**Name of primary insurance holder: ____________________________________ Date of birth: _________________________________**
**Member identification number: _______________________________________ Group number: _______________________________**
**Insurance phone number: ________________________________________________________________________________________**
**Primary insurance holder address: _________________________________________________________________________________**
**Phone number: ______________________________________________________**

**THIS SECTION TO BE COMPLETED BY WOMEN**

Are you pregnant? YES / NO Is there a possibility that you are pregnant? YES / NO Are you breast-feeding? YES / NO

Have you ever been pregnant? YES / NO

If YES: # pregnancies ________ # full term pregnancies ________ date (year) of each pregnancy _________________________________

Do you currently use (or have ever used) a contraceptive? YES / NO

If YES, indicate name(s) and years taken ______________________________________________________________

**A L L P A T I E N T S - P L E A S E I N I T I A L & S I G N**

Please add any additional comments: ______________________________________________________________________

**I certify that the above information is true to the best of my knowledge. _______**

**I certify that a HIPAA Form has been completed. _______**

**_______I understand that it is my responsibility to confirm all of my network benefits before services are rendered by Dr. David Green, and that I am responsible for my co-payment or deductible balance as well as any other fees incurred that are NOT covered by my insurance at the time of my visit.**

**_______I further understand that I will be responsible for any charges that are incurred on my behalf including insufficient funds, bank charges, attorney fees and/or collection fees.**

**_____ Cancellation Policy:** We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

**I UNDERSTAND THAT THERE IS A CHARGE FOR THIS CONSULTATION, depending upon the degree of complexity of my visit.**

**SIGNATURE: __________________________________________________________________ DATE: ________________________**