Aesthetics, Skin Care, DermaSurgery

LAWRENCE J. GREEN, M.D., LLC
15005 SHADY GROVE ROAD
SUITE 440
ROCKVILLE, MARYLAND 20850
301-610-0663

REGISTRATION INFORMATION

PATIENT NAME: ______________________________ SOC. SEC. NO. ____- ____- _____
LAST NAME FIRST NAME MI

ADDRESS: ______________________________ PATIENT OCCUPATION: ______________

CITY: ____________ STATE: ______ ZIP: ________ SEX: ☐M ☐F BIRTH DATE: _____/_____/_____

AGE: _____ HOW WERE YOU REFERRED? ____________ PRIMARY PHYSICIAN: ______________

HOME PHONE: ______________ CELL PHONE: ______________ WORK PHONE: ______________

EMERGENCY CONTACT: ______________ PHONE #: __________ RELATIONSHIP: __________

INSURANCE INFORMATION

- **POLICY HOLDER** OR
RESPONSIBLE PARTY (if a minor): ______________________ DATE OF BIRTH: __________

RELATIONSHIP TO PATIENT: ______________________ SOC. SEC. # ______________

ADDRESS (If different than patients): ______________________________

CITY: ____________ STATE: ____________ ZIP: ________ PHONE: ______________

- **PRIMARY INSURANCE COMPANY:** ______________________________

ADDRESS: ______________________________

ID or SUBSCRIBER # ______________ GROUP NAME OR NUMBER: ______________

- **SECONDARY INSURANCE INFORMATION:** ______________________________

ID OR SUBSCRIBER # ______________ GROUP NAME OR NUMBER: ______________

ASSIGNMENT AND RELEASE

We will bill your insurance company if we participate with that company. You are responsible for any & all charges that your insurance company does not cover such as deductibles, co-pays, and non-covered services, which are payable at the time of service. Parents are responsible for payments on child accounts. There is a $25 fee for returned checks. I authorize for insurance payments to go directly to the physician and for release of necessary medical records to the insurance company. If there is a balance due which is not received within 90 days, finance charges shall accrue at the rate of 1% per month, and the undersigned shall be liable for any necessary collection fees. HMO participants: Although we will try to assist you as best we can, in order for your insurance to pay for your visit, it is *your* responsibility to obtain referrals from your primary care physician for each visit to a specialist. Even if *our office makes a return visit for you, your referral may have expired. It is up to you to keep track of your referral validity.* I certify that I understand the above and that the information I have given is correct to the best of my knowledge.

X______________________________ DATE: ______________

Patient or Parent signature (if a minor)

Patient Name ______________________________ **Date** __________

1. Do you have history of non-melanoma skin cancer?
   If yes: Basal Cell Carcinoma? YES/NO
   Squamous Cell Carcinoma? YES/NO

2. Do you have a history of melanoma? YES/NO, If yes, Location? ________ Date________

3. Do you smoke? YES/NO, If yes, how much ________________

4. Do you drink? YES/NO, If yes, how much ________________

5. Are you taking any medications? YES/NO
   Please List: ____________ ____________
   ____________ ____________

6. Please list any medical problems:
   ____________ ____________
   ____________ ____________

7. Are you allergic to any medications? YES/NO, Please list:

Medicine	Reaction
____________	____________
____________	____________
____________	____________

Issues of interest to you (please check all that apply):

- ☐ Tumescent Liposuction
- ☐ Wrinkle Fillers (Juvederm Radiesse)
- ☐ Micro-Dermabrasion
- ☐ Chemical Peels (Superficial or Medium Depth)
- ☐ Renova or Avage
- ☐ Spider Vein Treatment on Face or Legs
- ☐ Torn Earlobe Repair
- ☐ Ear Piercing
- ☐ Laser Hair Removal
- ☐ Cosmetic Consultation
- ☐ Acne / Acne Scars
- ☐ Acne Facials
- ☐ European Facials
- ☐ Skin Care Advice / Products
- ☐ Mineral Make Up
- ☐ Sunprotective Beachwear
- ☐ Sunscreen Advice
- ☐ Other, please specify:

____

E-mail address ______________________________

May we use your e-mail to send information about our practice? ☐ Yes ☐ No

How did you hear about us?

- ☐ My physician
- ☐ Internet
- ☐ Insurance Company
- ☐ Friend, etc.

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OFFICE POLICY AND PROCEDURES

Welcome to the office of Dr Lawrence J. Green, MD. It is our goal to treat you with respect and understanding in the most professional way possible.

We have outlined our financial policy below so as to present a clear understanding of each other's responsibilities.

All payments are expected at the time of the visit. Our office accepts payments by cash, check, Visa and MasterCard. Unpaid charges in the excess of 90 days are subject to service charges. If a bill goes unpaid for more than 90 days it is subject to be sent to our collection agency- Cache Quest. ________________ (Initial here)

Insurance can be very confusing and a time-consuming task for everyone. Our office will gladly file **most** claims to your insurance carrier on your behalf. We will provide them with all the necessary documentation of your office visit.

Dr. Green is neither an agent nor an employee of the insurance company. The relationship we have is with you, our patient. If, for any reason, your insurance does **NOT** pay for services rendered by Dr. Green, you the patient are solely responsible for the balance. **YOU** are ultimately responsible for knowing and understanding your policy; its benefits, exclusions and limitations and need for referrals. _____________. (Initial Here)

A fee of $25.00 will be charged for any returned checks. There will be a $25.00 charge for any missed appointments without prior notice and a $50.00 charge for any missed surgical appointments without prior notice.

I _______________________, hereby acknowledge that I have read and understand the policies as stated. Any collection fees and attorney's fees that are incurred for breach of this agreement will be the sole responsibility of the patient.

____
Patient Name (please print)

____
Date

____
Patient or Guardian Signature

9/06

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WELCOME TO OUR PRACTICE

WE WOULD LIKE YOU TO ENJOY 10% OFF ANY COSMETIC PRODUCT OR PROCEDURE EITHER PERFORMED OR SCHEDULED AT YOUR INITIAL OFFICE VISIT.

Please bring coupon with you to your first visit