

DERMATOLOGY ASSOCIATES OF MCLEAN, LTD.

WILLIAM J. ALMS, M.D.

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PLEASE PRINT

DATE

Mr. Mrs. Ms. Miss Dr.	PATIENT'S LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	SEX M F
ADDRESS	CITY, STATE		ZIP
HOME PHONE ()	CELL PHONE ()		
REFERRED BY	FAMILY DOCTOR		
OCCUPATION	EMPLOYER	WORK PHONE ()	
EMERGENCY CONTACT NAME	RELATIONSHIP	WORK PHONE ()	HOME PHONE ()

INSURANCE INFORMATION

PRIMARY INSURANCE	ID #	GROUP #	
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
HOME PHONE ()	WORK PHONE ()	CELL PHONE ()	
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY, STATE		ZIP
SECONDARY INSURANCE	ID #	GROUP #	
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
HOME PHONE ()	WORK PHONE ()	CELL PHONE ()	
ADDRESS OF INSURANCE COMPANY	CITY, STATE		ZIP

FINANCIALLY RESPONSIBLE PERSON IF DIFFERENT FROM INSURANCE HOLDER

NAME	HOME # ()	WORK # ()	CELL # ()
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY, STATE		ZIP

We do not participate with any insurance except Medicare. We ask for this insurance information to provide an accurate claim form for you to submit to your insurance company. We keep insurance information on file in order to identify your insurance company if they should call with questions regarding your claim. We also need this information to comply with federal laws which regulate charges to patients with Medicare and Tricare (Primary or Secondary) and retired Federal Employee Health Benefits (age 65 or older). We file claims only for Medicare and Primary Tricare patients. If you have any questions, please speak with one of our staff members.

Thank you.