PATIENT INFORMATION

First Name	M.I.	Last Name	
Street Address		City	State
Zip Code	Home Phone #	Work Phone #	Cell Phone #
Birth Date	Age	Sex (circle one) F M	Race	Marital Status	Spouse's Name
E-mail Address		Preferred Phone Number:	

RESPONSIBLE PARTY OR INSURANCE POLICY HOLDER (IF OTHER THAN PATIENT)

First Name	M.I.	Last Name	
Street Address		City	State
Zip Code	Home Phone #	Work Phone #	Cell Phone #	Birth Date

Who may we thank for referring you to our office?	Please tell us the name of your primary/referring physician:

Please read and check the boxes below:

☐ I understand this office **ONLY** participates with Medicare Part B insurance and I will be responsible for today's services if I do not have Medicare Part B as my **primary** insurance.

☐ I understand that if payment is required, it is due at the time of service and this office ONLY accepts Visa, AMEX, Master Card, Discover, and EXACT cash.

PLEASE NOTE: FOR ALL SCHEDULED APPOINTMENTS IN WHICH NOTIFICATION OF CANCELLATION IS NOT MADE AT LEAST 24 HOURS PRIOR TO APPOINTMENT TIME; YOU WILL BE CHARGED A FEE OF $50.00. FOR SURGICAL AND COSMETIC APPOINTMENTS, THIS FEE INCREASES TO $100.00 DUE TO THE LENGTH OF TIME SET ASIDE FOR THESE APPOINTMENTS. EXCEPTIONS WILL BE MADE ONLY IN THE CASE OF AN EMERGENCY, AND AT THE DISCRETION OF THE OFFICE MANAGER. PLEASE SIGN BELOW AS ACKNOWLEDGEMENT OF THIS POLICY.

Signature: _____ Date: _____

PAYMENT IS DUE AT TIME OF SERVICE!
WE ACCEPT: VISA, MASTERCARD, DISCOVER, AMEX, or EXACT CASH!

Chevy Chase Dermatology Center (CCDC)

Patient Name:

_____

Privacy Instructions

Contacting You

We take your privacy very seriously. Please let us know how we may contact you to remind you about appointments, discuss lab test results, and other matters.

	Specify your Phone Number	OK to Leave Detailed Message	Leave Message with our practice name and callback number only	Do Not Call
Home	( ) -	☐	☐	☐
Work	( ) -	☐	☐	☐
Cell	( ) -	☐	☐	☐
Fax	( ) -	☐	☐	☐
Other	( ) -	☐	☐	☐

Normally, CCDC will NOT contact you via email. However, in the event of any breach of confidentiality or security, email will be the fastest way to advise you.

Email Address: _____

☐ I authorize CCDC to notify me via email in the event of a data breach

Others we may speak with

Please give us guidance regarding speaking with any family or friends when we call, or if they contact us regarding your care and/or payment for your care. It is OK for CCDC to speak with:

Name	Relationship	Phone	Date of Birth

I have received the HIPAA Notice of Privacy Practices and have provided the above instructions.

Patient Signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

For Office Use Only

CCDC made a good faith effort to obtain the above information.

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining this acknowledgement

☐ Other _____

Staff Signature: _____ Date: _____

HISTORY AND INTAKE FORM

NAME: _____ **DATE OF BIRTH:** _____

Primary Doctor: _____ **Referring Doctor:** _____

Past Medical History: (please circle all that apply)

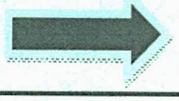
Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

PLEASE TURN OVER!!!

Thank you



Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Excessive Sweating
None
Other _____

*Do you have a family history of Melanoma?

Yes No

If yes, which relative(s)? _____
Any other family history: _____

* Do you have a family history of Diabetes? If yes please circle below

Mother Father Sister Brother

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____

Social History: (Please circle one)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Language:
English
Spanish
Other: _____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Pharmacy: Name: _____

Pharmacy Address: _____ Zipcode: _____

Telephone Number: _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Excessive Sweating
None
Other _____

*Do you have a family history of Melanoma?

Yes No

If yes, which relative(s)? _____
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*** Do you have a family history of Diabetes?** If yes please circle below

Mother Father Sister Brother

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____

Social History: (Please circle one)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Language:
English
Spanish
Other: _____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Pharmacy: Name: _____

Pharmacy Address: _____ Zipcode: _____

Telephone Number: _____

HISTORY AND INTAKE FORM

NAME: _____ **DATE OF BIRTH:** _____

Primary Doctor: _____ **Referring Doctor:** _____

Past Medical History: (please circle all that apply)

Anxiety
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Artificial joints
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Atrial fibrillation
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Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
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Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
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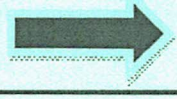
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

PLEASE TURN OVER!!!

Thank you



SAMANTHA A. TOERGE, M.D.

THE BARLOW BUILDING
5454 WISCONSIN AVE. SUITE 1400
CHEVY CHASE, MD 20815

TELEPHONE: (301) 951-7905
FAX: (301) 951-7011

Patient's Name: _____

Parent or Guardian (print): _____

Date: _____

_____ I may not come to all office visits with my child, and authorize Dr. Samantha Toerge to treat him/her in my absence. I understand that this means that Dr. Toerge will make medical decisions regarding my child's care, in consultation with my child, and that Dr. Toerge will not hesitate to call me to discuss treatment decisions when she feels that parental involvement would be advisable. I also understand that if I wish to be directly involved in the details of my child's care, I should be present at all scheduled appointments in order to allow productive discussion of possible care plans. Any time I choose not to attend an appointment, I will ensure that I have provided my child with or otherwise arranged for payment of whatever fees are due at the time of the visit.

_____ I do not wish to have my child seen when I am not present, and will be available to attend all scheduled appointments.

_____ I will not be able to attend all of my child's appointments, but agree to allow them to be accompanied by another person (name: _____). I understand that the policy outlined above for visits when a parent is not present will apply.

Signature: _____ Date: _____