Dr. Leon E. Brown M.D., P.A.
7610 Carroll Avenue, Suite 460
Takoma Park, MD 20912
Phone: (301)270-5400 Fax: (301) 270-5402
medicalskincarectr@gmail.com

PATIENT INFORMATION

Last Name ________________________ Social Security #

First Name ________________________ Sex: M F

Middle Name ________________________ Race: Native Amer Asian Black Caucasian Mixed Other

Address__________________________ Apt________ Hispanic: Yes No

City ________________ State_____ Zip__________ Preferred Language: ________________________

Marital Status: S M D W

***Cell Phone** (___)____-________________ Birth Date: / /

Home Phone (___)____-________________ Occupation: ______________________________

Work Phone (___)____-________________ ***Email** ________________________________

Emergency Contact: ________________________ Phone Number: (___)____-______ Relationship: _________________

*****NOTICE:** If your insurance policy requires a referral to see a specialist, you MUST provide the referral before your visit. Your referral must be from your Primary Care Doctor (PCP). If you are unsure if a referral is required to see a specialist, please call the member services number for your plan. **Failure to provide a referral may result in you being billed for the FULL CHARGED AMOUNT of the visit.**

Do you have insurance? Y / N

Referral REQUIRED? Y / N

Primary Care Doctor (PCP): Name__________________________ Phone:_____________________________

INSURANCE: Primary Subscriber/Holder: Name_____________________ Birth Date:___________________
(Write "SELF" if you are the primary subscriber)

eRx:
Dr. Brown now sends prescriptions directly to pharmacies as electronic prescriptions (eRx). The pharmacy can be any of your choosing. Please provide your selected pharmacy's information below:

Pharmacy Name: _________________ Phone: _________________ Address: _____________________________

ACKNOWLEDGEMENT: I am advised that there are no guarantees in regards to medical care. Physicians give their best effort based on their experience. A second opinion by a physician of my choosing or Dr. Brown's is welcomed. I should never feel forced to follow a treatment plan, but only after a thorough understanding agree that the cause given is capable of safely getting the desired results. There are times in which Dr. Brown may suggest the use of a medication in a way that is not originally intended, but based on Dr. Brown's experience and my understanding; I feel it can safely get the desired result. I have been given an opportunity to ask questions about my treatment and encouraged to call if there are any problems related to medications or changes in disease condition. I am responsible for all possible balances not paid by insurance, and for any laboratory analysis due to co-insurance, deductibles, denials, or any other fees. If my bill is sent to a collection company I understand that I will be responsible for all charges incurred that are lawful.

____ ____________________
Signature of Patient, Guardian, Subscriber or Beneficiary **Date**

I hereby authorize Leon E Brown MD to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to Leon E Brown MD. In the event that my insurance does not pay for my services, or if I am a self-pay patient, I understand and agree that I am responsible for my entire bill. I certify that the information I have reported with regard to my information including medical information to the insurance company in order to determine insurance benefits to which I am entitled. This authorization may be revoked by either myself or my insurance company at any time, but in any event expires one year after the date of my signature.

____ ____________________
Signature of Patient, Guardian, Subscriber or Beneficiary **Date**

All Office Visit Payments/Co-Pays are Due BEFORE Seeing Dr. Brown