Welcome to Our Office

Rhonda Rand, M.D. Inc. 436 N. Roxbury Drive Suite 212 Beverly Hills, CA 90210

*****PLEASE PRINT*****

(Circle One) Sex: M/F (Circle One) Title: Miss/Ms./Mrs./Mr./Dr.

Name: _____
Last First Middle

Home Address: _____
Street City Zip

Billing Address: _____
Street City Zip

Cell Phone: ( )_____ Home Phone: ( )_____

Work Phone: ( )_____ Ext._____ Email Address: _____

SS#: _____-_____-_____ DL #: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Whom May We Thank for Referring You? _____
(MD/Clinic/Friend/Family)

Other Referral: _____ (Magazine, Internet, Yellow Pages, Insurance)

Employer: _____ Occupation: _____

Work Address: _____

If Married: _____ Spouse's Name

Person to be called in case of Emergency: _____

Relationship: _____ Phone Number: _____

Address: _____

Primary Care Doctor:_____ Phone Number:_____

Insurance Information (Provide if Requested):

Type of Insurance: _____ Subscriber Name: _____

ID #: _____ Grp #: _____

Relationship to Sub: (Self/Spouse/Child/Parent/Employer/Other)

Subscriber Address: _____DOB: _____

I UNDERSTAND THAT PICTURES WILL BE TAKEN FOR MY SECURE MEDICAL RECORD; FOR IDENTIFICATION PURPOSES AND TO MONITOR PROGRESS.

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF I AM AN INDUSTRY HEALTH NETWORK, ANTHEM BLUE CROSS, OR MEDICARE PATIENT, I ASSUME RESPONSIBILITY FOR ANY SERVICES THAT ARE COSMETIC OR NOT PART OF MY REFERRAL, AND WILL PAY FOR THOSE SERVICES AT THE TIME THEY ARE PROVIDED.

Signature: _____ Date: _____