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

Minor's Name: _____
Last First Middle

Home Address: _____
Street City Zip

Billing Address: _____
Street City Zip

Our automated appointment reminder calls will go to the preferred number provided below

Preferred Phone: ( ) _____ Other Phone: _____

Email Address: _____

Social Security #: _____-_____-_____ DL #: _____

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

Mother's Name: _____ Father's Name: _____

Mother's Cell Phone: ( ) _____ Father's Cell Phone: ( ) _____

Mother's Employer: _____ Father's Employer: _____

Mother's Occupation: _____ Father's Occupation: _____

Whom May We Thank for Referring You? _____

(MD/Clinic/Friend/Family/Magazine/Internet/Insurance)

Person to be called in case of Emergency: _____
Relationship: _____ Phone Number: _____
Address: _____
Primary Care Doctor:_____ Phone Number:_____
Insurance Information (Not needed if we were able to obtain a copy of your card):
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 of Guardian:_____ Date: _____