THE
DERMATOLOGY & COSMETIC CARE CENTER

STANLEY S. ROLAND, D.O.
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174 South Main Street, Romeo (586)752-4100
526 W Genesee, Frankenmuth (866)593-2313
www.stanleysroland-do.com

Today's Date: _____ Account #: _____

PATIENT INFORMATION:

Last Name: _____
First Name: _____
Middle Name/Suffix: _____
Previous Last Name: _____
Date of Birth: _____ Male / Female
Social Security #: _____
Home Address: _____
_____
Home #: _____
Work #: _____
Mobile #: _____
Email: _____
Preferred Language: _____
Race: _____ Ethnicity: _____

EMERGENCY CONTACT INFORMATION:

Name: _____
Relationship to Patient: _____
Phone #: _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION:

Relationship to you: _____
Full Name: _____
Date of Birth: _____
Social Security #: _____

Pharmacy: _____
Pharmacy #: _____
Primary Care Physician: _____
Referred by: _____

PRIMARY INSURANCE INFORMATION:

Subscriber: _____
Date of Birth: _____
Subscriber SS#: _____
Relationship of patient to subscriber: _____

SECONDARY INSURANCE INFORMATION:

Subscriber: _____
Date of Birth: _____
Subscriber SS#: _____
Relationship of patient to subscriber: _____

Do we have your permission to:

☐ Leave a message at: **Home**: Yes/No **Work**: Yes/No **Mobile**: Yes/No

☐ Discuss your medical condition or financial information with any member of your household? Yes/No
If yes, whom & relationship: _____

I have received or been offered a copy of the Notice of Privacy Practices from the office of Dr. Stanley Roland.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE:** _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Stanley S. Roland, D.O., P.C..

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE:** _____

I understand and agree that, (regardless of my insurance status) **I AM ULTIMATELY RESPONSIBLE** for the balance on my account for any professional services rendered. I have read and filled out all of the information to the best of my ability. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or insurance status as indicated in the above information.

MONTHLY SERIVCE CHARGES OF 1.5% (TIME/PRICE DIFFERENTIAL ARE ASSESSED ON UNPAID BALANCES). UNLESS CANCELLED 24 HOURS IN ADVANCE, $75.00 WILL BE CHARGED FOR MISSED APPOINTMENTS. ALSO FOR NO SHOW SURGERY APPOINTMENTS $150.00 PER EACH 30 MINUTES OF MISSED APPOINTMENT TIME WILL BE CHARGED.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE:** _____