True Physician Care, LLC
10215 Fernwood Road, Suite 405
Bethesda, Maryland 20817

General Information [please print]

Name: _____ DOB: _____ Gender Identity: M F NB
Social Security #: _____ Marital Status: Single Married Divorced Widowed Domestic Partner

Primary Address: _____
City: _____ State: _____ Zip Code: _____
Telephone -- Mobile: _____ Work: _____ Home: _____
Email: _____
Employment Status: Employed Unemployed Retired Student
Employer/School: _____ Occupation: _____

Preferred Pharmacy

Pharmacy Name/Address: _____
Telephone: _____ Fax: _____

Insurance Information

Subscriber Name: _____
Relationship to Patient: _____ Identification Number: _____
Insurance Company Name: _____ Group Number: _____
Insurance Company Address: _____

Authorization For Treatment

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician or designated providers.

Financial Responsibility

I UNDERSTAND THAT TRUE PHYSICIAN CARE, LLC DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANY.

I acknowledge that I have read the above statement and further acknowledge that I am personally responsible for payment of all charges not paid in full by insurance.

_____ _____
Parent/Guardian Signature Date