PATIENT INFORMATION - PLEASE PRINT

Full Name ____
(Last) (First) (Middle) (Maiden) Date

Mailing Address ____
(City) (State) (Zip)

Age ____________ Date of Birth ________________ ________Male ________Female
(Mo) (Day) (Yr)

Social Security Number ____________________ Marital Status S M D W

Home Phone ____________________ Work Phone ____________________

Alternate # ____________________ Pharmacy Name ____________________

Patient's Employer ____________________ Pharmacy Phone ____________________

Address ____

RESPONSIBLE PARTY INFORMATION

Name ____________________ Address ____________________

Birthdate ____________ Social Security No. ____________________Phone ____________

Employer ____________________ Relationship to Patient ____________________

Required by Federal Government

Preferred Language____________________ **Gender**: ❑ Male ❑ Female

Race: ❑ African American ❑ Alaska Native ❑ American Indian ❑ Asian ❑ Native Hawaiian ❑ Pacific Islander
❑ White ❑ Other Race ❑ Declined to Specify

Ethnic Group: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to Specify

Smoking Status *(Patients 13 years of age or older)*: ❑ Current Every Day Smoker ❑ Current Some Day Smoker
❑ Former Smoker ❑ Never Smoker ❑ Smoker Current Status Unknown ❑ Unknown If Ever Smoked

Family Physician Full Name:____________________ **Phone**:____________

Address:____

____

Referring Physician Full Name: ____________________ **Phone**:____________

Address:____

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OVER

MEDICAL INSURANCE: If your insurance policy requires a copayment, percentage, or deductible, this amount is payable at the time services are rendered. If our office is not a participating provider for your insurance or if a required referral has not been obtained, then payment is expected in full at the time of service.

PRIMARY MEDICAL INSURANCE COMPANY: ______________________________

NAME ______________________________

ID NUMBER ______________________________ GROUP NUMBER ______________________________

SUBSCRIBER BIRTHDATE ______________________________ EMPLOYER ______________________________

COPAYMENT/PERCENTAGE REQUIRED FOR OFFICE VISIT: $ ______________________________

SECONDARY MEDICAL INSURANCE PLAN: ______________________________

NAME ______________________________

ID NUMBER ______________________________ GROUP NUMBER ______________________________

SUBSCRIBER BIRTHDATE ______________________________ EMPLOYER ______________________________

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION TO ABOVE INSURANCE COMPANIES

I, ______________________________, hereby assign all medical and/or surgical benefits to Dermatology Associates, PA. This includes major medical benefits. Medicare and Government sponsored programs, private insurance or other.

This assignment of benefits will remain in effect until revoked by me in writing. I understand that I am responsible for all applicable COPAYMENTS, COINSURANCE, and NON-COVERED SERVICES as required by my insurance policy.

I hereby authorize DERMATOLOGY ASSOCIATES, PA, to release all information necessary, including medical records to secure the payment of insurance benefits.

SIGNATURE ______________________________ **DATE** ______________________________