DERMATOLOGY™
ASSOCIATES, P.A.

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 _____

Cell Phone _____ Pharmacy Name _____

Patient's Employer _____ Pharmacy Phone _____

Email Address _____

RESPONSIBLE PARTY INFORMATION

Name _____ Address _____

Birthdate _____ Social Security No. _____Phone _____

Employer _____ Relationship to Patient _____

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**:_____

How did you hear about our office?

❑ **Doctor** _____(Doctor's Name) ❑ **Family Member / Friend** ❑ **Internet / Social Media**

❑ **Other**_____

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** _____