Welcome To Our Office

PLEASE PRINT and COMPLETE ALL PARTS

AboutSkin Dermatology and DermSurgery, PC

Responsible Party Number _____

PATIENT NAME: (This section refers to PATIENT ONLY) Today's Date_____

Name _____

Address _____ City _____ State _____ Zip _____

Phone 1: _____ (home/cell/work) Phone 2: _____ (home/cell/work)

Date of Birth _____ Age____ Sex ____ Social Security # _____

Employer _____ Occupation _____

Email Address: _____ Permission to Send Newsletter/Information ☐ Yes ☐ No

Spouse _____ Employer _____ Phone _____

RESPONSIBLE PARTY: (Person who should receive the bill)

Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Date of Birth _____ Age_____ Employer_____

HOW DID YOU HEAR ABOUT US?:_____

REFERRING PHYSICIAN NAME :_____ **PHONE:**_____

PRIMARY CARE PHYSICIAN (PCP): _____ **PHONE:**_____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone: Area ( ) _____	Phone: Area ( ) _____
Primary Insured Person _____	Primary Insured Person _____
ID/Policy # _____ Suffix_____	ID/Policy # _____ Suffix_____
Group # _____	Group # _____
Employer_____	Employer_____
Co-Payment $_____	Co-Payment $_____
Auto Injury ☐ Claim #_____	Date of Accident_____
Work Comp ☐ Claim #_____	Date of Accident_____
Other Injury (Specify)_____	Date of Accident_____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name_____ Relationship_____ Phone_____

CONSENT FOR TEST RESULTS I give AboutSkin Dermatology and DermSurgery, PC permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply)

☐ Voice mail at work ☐ Answering machine at home ☐ Other_____ ☐ Do not leave message

I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Patient name:_____ Date:_____

Signature:_____ Relationship to patient: ☐ self ☐ parent ☐ guardian (check one)

March 2015