INFORMATION SHEET **DERMATOLOGY, P.C.** **PLEASE PRINT**

Name _____ _____ _____
Last First M.I. Sex Date of Birth Marital Status

Address _____ _____
Social Security Number

City, State, ZIP _____ _____
Home Phone

*If home address is different than billing address please mark here. ☐

Employer _____ _____
Work Phone

Cell Phone _____ Email _____

Referred By _____ Family Physician _____

Spouse or Parent Name if Patient is a Minor **Home Phone Number** **Work Phone Number**

In the event Dermatology, P.C. is unable to reach me, I authorize you to call the following person for a number where I can be reached:

Name _____ Relationship _____ Phone Number _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID# _____

Name of card holder | Relationship to Patient | Date of Birth | Social Security Number

Home Address | Address/City/State/Zip | Home Phone

Card Holder's Employer | Address/City/State/Zip | Work Phone

SECONDARY INSURANCE _____ ID# _____

Name of card holder | Relationship to Patient | Date of Birth | Social Security Number

Home Address | Address/City/State/Zip | Home Phone

Card Holder's Employer | Address/City/State/Zip | Work Phone

Notification of Lab / Pathology Requirements

If your insurance requires a specific laboratory, other than our internal laboratory, please list:

_____

RELEASE OF INFORMATION TO FAMILY MEMBER OR FRIEND

In the event Dermatology, P.C. is unable to reach me by phone, I authorize release of information regarding office appointments, surgery times, biopsy (pathology) results to:

Or ☐ I **do not** authorize release of information to anyone except me personally.

☐ I authorize release of information regarding office appointments, surgery times, biopsy results to:

Name _____ Relationship _____ Phone Number _____

Signature _____ Date _____

AUTHORIZATION FOR TREATMENT AND INSURANCE CLAIM FILING

I, the undersigned hereby authorize examination and any other medical services deemed necessary by the physicians of Dermatology, P.C. I authorize the physicians of Dermatology, P.C. to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me.
I, the undersigned, authorize payment of medical benefits to the physicians of Dermatology, P.C. for services rendered to me. I understand I am financially responsible for any amount not covered by my insurance contract. I authorize release of information acquired in the course of my examination to any other physician(s) involved in my care.

DATE _____ **SIGNATURE** _____

DATE _____ **SIGNATURE** _____

Medicare Authorization: I, the undersigned, authorize the physicians of Dermatology, P.C. to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed to determine benefits payable for related services. I authorize the same information be sent to my secondary insurance carrier (Supplemental Insurance-Medigap Coverage). I authorize the payment of Medigap benefits to Dermatology, P.C. for any services furnished to me.

Name of Secondary (Medigap) carrier: **Signature** **Date**

Review other side

Dermatology, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-515-241-2000.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-515-241-2000.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-515-241-2000。