DERMATOLOGY ASSOCIATES, LLC

***ADULT PATIENT INFORMATION** **New Patient** **Established/Update**

***SEE REVERSE SIDE TO ENTER MINOR/CHILD INFORMATION**

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: **TODAY'S DATE: _____**

Patient's Name: _____
Last *First* *M.I.*

Date of Birth: ____/_____/_____ Age: _____ Sex: □ Male □ Female Social Security #:_____-____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Preferred Phone #: □ Home □ Cell □ Work E-Mail: _____

ADDRESS:

Mailing Address: _____
City State Zip

Winter Address: _____ Winter Phone: ( ) _____
(If applicable) City State Zip

Race: □American Indian or Alaska Native □ Asian □ Native Hawaiian □ White □ Black or African American
□ Other Pacific Islander □ Other Race □ Hispanic

Ethnicity: □ Hispanic □ Non-Hispanic

Preferred Language: □ English □ French □ Indian □ Spanish □ Russia □ Chinese □ Sign Language □ Other _____

In case of Emergency, whom should we notify? _____ Relationship to Patient: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Employment Information:
Employer: _____ Occupation: _____

Primary Care Physician Information:
Full name of Primary Care Physician (PCP): _____
First Last
Phone #: _____ Address: _____
City State

Did your Primary Care Physician (PCP) refer you to this office? Yes No If no by whom? _____

Insurance Information:

Primary: □ HMO (PCP Referral required**) □ PPO**

Insurance Co. Name: _____

Certificate #: _____

Group #: _____

Phone: ( ) _____

Name of Insured (Guarantor): _____

Date of Birth: ____/____/_____ SSN #:____/___/_____

Secondary: □ HMO (PCP Referral required**) □ PPO**

Insurance Co. Name_____

Certificate #:_____

Group #: _____

Phone: ( ) _____

Name of Insured (Guarantor): _____

Date of Birth:____/____/_____ SSN #: _____/____/_____

Release of Information Authorization:

I hereby authorize release of MEDICAL INFORMATION necessary to process claims for services provided by the Medical Staff at Dermatology Associates. I also hereby authorize release of MEDICAL BENEFITS directly to Dermatology Associates, LLC. I understand that even though I have some type of insurance I am responsible for payment of services.

Patient Signature: _____ Date: _____

Please present your insurance card(s) to check-in along with this completed form.