DERMATOLOGY ASSOCIATES, LLC

MINOR/ CHILD INFORMATION **New Patient** **Established/Update**

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

Minor's Name: _____ Prefer to be called: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Social Security #: _____-____-_____

Mailing Address: _____
City State Zip

Home Phone #: _____ Cell Phone #: _____

Legal Guardian or Parent Name: _____
First Middle Last

Phone (day): ( ) _____ Phone (evenings): ( ) _____

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: ( ) _____

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 #: _____/____/_____

Payment Policy: The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

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. I understand that even though I have some type of insurance I am responsible for payment of services.

Parent/ Legal Guardian Signature _____ Date: _____

Permission to treat a Minor:

Many times parents find themselves unable to accompany their teen or young adult children to appointments. Your signature will give us permission to treat should you be unable to accompany your child. Permission is good for one year.
I hereby give my permission to have my child treated when they arrive at the office unaccompanied.

Parent/Legal Guardian: **Date**

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