DERMATOLOGY ASSOCIATES, LLC

<u>ADULT</u> NEW PATIENT INFORMATION

Patient's Full Name: _____ **Date of Birth:** _____
First MI Last (Preferred) MM/DD/YYYY

Mailing Address: _____/_____/_____/_____
Street Number or PO Box City State Zip

Alternative Address: _____/_____/_____/_____
(If applicable, i.e. winter or summer address) Street Number or PO Box City State Zip

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

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

Marital Status: □ Single □ Married □ Divorced □ Widowed Social Security #: _____-_____-_____

Birth Sex: □ Male □ Female Preferred Pronouns: □ He/Him/His □ She/Her/Hers □ They/Them/Theirs

Race:

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

Preferred Language:

□ English □ French □ Indian □ Spanish
□ Russian □ Chinese □ Sign Language
□ Other _____

Ethnicity:

□ Hispanic □ Non-Hispanic

Employment Information:

Employer: _____ Occupation: _____ Retired: □

Emergency Contact Information:

In case of Emergency, please notify: _____ Relationship to Patient: _____

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

Primary Care Provider Information:

Full name of Primary Care Provider (PCP): _____ Phone #: _____

Did your PCP listed above refer you to this office? □ Yes □ No, self-referred □ No, referred by: _____

Insurance Information: ******Please present your insurance card(s) at check-in along with this completed form.******

Insurance Company:_____ □ HMO **(**PCP referral required**)** □ PPO

Secondary Insurance: _____ □ Self-pay/no insurance

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:_____