DERMATOLOGY ASSOCIATES, LLC

<u>MINOR/CHILD</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

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

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

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

Parent/Legal Guardian Full Name: _____
First MI Last

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

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

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

Primary Care Physician Information:

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

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

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

Please Note Payment Policy: *The Adult/Guardian/Parent who brings the child to the appointment will be responsible for all balances due including coinsurance, copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.*

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.

Parent/Legal Guardian Signature: _____ Date:_____

<u>Permission to treat a Minor:</u>

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. <u>Permission is good for one year</u>.

I hereby give my permission to have my child treated when they arrive at the office unaccompanied.

Parent/ Legal Guardian Signature: _____ Date: _____