DERM ONE
Dermatology Care

NEW PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S SS#:_____ DATE:_____

PATIENT'S NAME _____ HOME PHONE NO. _____

STREET ADDRESS or POST OFFICE BOX_____

CITY, STATE, and ZIP_____

MALE_____ FEMALE_____ DATE OF BIRTH_____ AGE _____ MARITAL STATUS: SINGLE or MARRIED

PATIENT'S EMPLOYER_____ WORK PHONE_____

EMPLOYER'S ADDRESS_____

SPOUSE'S NAME_____ SPOUSE'S BIRTHDATE _____

SPOUSE'S EMPLOYER_____ EMPLOYER'S ADDRESS_____

MINORS ONLY (UNDER 18 YEARS OF AGE)

FATHER'S NAME & ADDRESS_____

FATHER'S BIRTHDATE_____ SS #_____ WORK PHONE_____

FATHER'S EMPLOYER & ADDRESS_____

MOTHER'S NAME & ADDRESS _____

MOTHER'S BIRTHDATE_____ SS #_____ WORK PHONE_____

MOTHER'S NAME & ADDRESS _____

INSURANCE INFORMATION

FIRST INSURANCE COMPANY NAME AND ADDRESS_____

_____

POLICY AND GROUP NUMBER_____ ID NUMBER _____

INSURED'S NAME SECOND INSURANCE COMPANY NAME AND ADDRESS_____

_____

POLICY AND GROUP NUMBER_____ ID NUMBER _____

INSURED'S NAME_____ INSURED'S SOCIAL SECURITY NO. _____

REFERRING PHYSICIAN_____ DRUG ALLERGIES_____

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED _____ DATE_____

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON)

SIGNED (INSURED OR AUTHORIZED PERSON) _____

The undersigned herewith authorizes **Derm One PLLC** to receive and/or release medical data, medical history and/or other information to any hospital, physician, agency, or person if such a release of information is for the purpose of consultation, prescription or future treatment and in the interest of the proper management of your medical condition/disability.

By signing below, I hereby acknowledge Receipt of Derm One PLLC Notice of Privacy Practice and consent to the uses and disclosures described in the Notice of Privacy practices. I agree to all the above policies of Derm One PLLC.

_____ _____
Signature - Patient, Parent or Guardian Date

_____ _____
Witness Date

MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature: _____ Date_____