

NEW PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S SS# _____ DATE _____

PATIENT'S NAME _____ HOME PHONE NO. _____

MAILING ADDRESS _____

CITY, & STATE _____ ZIP _____

EMAIL _____

MALE _____ FEMALE _____ DATE OF BIRTH _____ AGE _____ MARITAL STATUS: SINGLE or MARRIED

PATIENT'S EMPLOYER _____ WORK PHONE _____

EMPLOYER'S ADDRESS _____ PHONE _____

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 EMPLOYER & ADDRESS _____

INSURANCE INFORMATION

FIRST INSURANCE COMPANY NAME AND ADDRESS _____

POLICY AND GROUP NUMBER _____ ID NUMBER _____

SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS # _____

SECOND INSURANCE COMPANY NAME AND ADDRESS _____

POLICY AND GROUP NUMBER _____ ID NUMBER _____

SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS # _____

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 _____