Dermatology East

PATIENT INFORMATION **Current Date:**

Name: Date of Birth: Age:

Gender Social Security #

Address City State Zip

Employer/School Occupation

Race Hispanic or Latino Language: English, Other:

Home Phone Cell Phone Work Phone

May we leave a message about your health information on your phone: Home ; Cell

May we discuss your health information, including lab results, with a family member? ;

If so, please list their name, relationship and phone #:

Family members who have seen Drs. Churchwell / Schneider:

Physician who referred you: Primary Care Physician:

INSURANCE - Please bring your insurance card(s) and driver license and provide them to the front desk.

Primary Insurance: Secondary Insurance:

RESPONSIBLE PARTY / INSURANCE POLICY HOLDER INFORMATION – if different than above

Please fill out this information if the Patient is under 18 or the patient is not the insurance policy holder on insurance card.

Date of Birth Gender Social Security #

Name

Street City State Zip

Home Phone Cell Phone Work Phone

Employer/School Occupation

Relationship to Patient

Pharmacy Information

Pharmacy Name: Pharmacy Phone Number:

Pharmacy Address:

AGREEMENT

1. I request that payment of authorized insurance benefits be paid to Dermatology East, P.L.L.C. for services rendered.
2. I authorize the release of any medical information needed to determine these benefits to the Insurance company.
3. I authorize the release of medical information to the referring or consulting physician.
4. I acknowledge that a copy of Dermatology East's Notice of Privacy Practices was provided or made available to me.
5. I understand that procedures not covered by insurance are due at the time of service and/or are my responsibility.
6. I agree that my co-pay is due at the time of service and if not collected is still may responsibility.
7. I understand that services are provided to me and not the insurance company and that I am financially responsible for all charges whether or not my insurance covers such charges.
8. I have read this form and certify this information is true and correct to the best of my knowledge.

Signed: _____ Date:

Print Name: