

**INFORMATION SHEET**

**DERMATOLOGY, P.C.**

**PLEASE PRINT**

Name \_\_\_\_\_  
 Last First M.I. Sex Date of Birth Marital Status

Address \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

City, State, ZIP \_\_\_\_\_  
 Home Phone \_\_\_\_\_

Employer \_\_\_\_\_  
 Work Phone \_\_\_\_\_

Referred By \_\_\_\_\_ Family Physician \_\_\_\_\_

Spouse or Parent Name if Patient is a Minor \_\_\_\_\_ Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

**In the event Dermatology, P.C. is unable to reach me, I authorize you to call the following person for a number where I can be reached:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**BILLING AND INSURANCE INFORMATION**

**PRIMARY INSURANCE** \_\_\_\_\_ ID# \_\_\_\_\_

Name of card holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_ Address/City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Card Holder's Employer \_\_\_\_\_ Address/City/State/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ ID# \_\_\_\_\_

Name of card holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_ Address/City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Card Holder's Employer \_\_\_\_\_ Address/City/State/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

**Notification of Lab / Pathology Requirements**

If your insurance requires a specific laboratory, other than our internal laboratory, please list:

\_\_\_\_\_

**RELEASE OF INFORMATION TO FAMILY MEMBER OR FRIEND**

**In the event Dermatology, P.C. is unable to reach me by phone, I authorize release of information regarding office appointments, surgery times, biopsy (pathology) results to:**

- Or  I do not authorize release of information to anyone except me personally.  
 I authorize release of information regarding office appointments, surgery times, biopsy results to:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT AND INSURANCE CLAIM FILING**

I, the undersigned hereby authorize examination and any other medical services deemed necessary by the physicians of Dermatology, P.C. I authorize the physicians of Dermatology, P.C. to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. I, the undersigned, authorize payment of medical benefits to the physicians of Dermatology, P.C. for services rendered to me. I understand I am financially responsible for any amount not covered by my insurance contract. I authorize release of information acquired in the course of my examination to any other physician(s) involved in my care.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**Medicare Authorization:** I, the undersigned, authorize the physicians of Dermatology, P.C. to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed to determine benefits payable for related services. I authorize the same information be sent to my secondary insurance carrier (Supplemental Insurance-Medigap Coverage). I authorize the payment of Medigap benefits to Dermatology, P.C. for any services furnished to me.

Name of Secondary (Medigap) carrier: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_