Patient Information (Please use your legal name)

Last ______________________________ First _____________________________________ Middle_____________________

Nickname__________________ SS# _____________________ Birth Date ____/____/____ Gender M ☐ F ☐

Mailing address ____ Apt # ________________

City ____ State_______________________ Zip __________________

Primary Phone _______________________ Cell/Home/Work Alt Phone ______________________ Cell/Home/Work

E-mail____ Preferred method of contact: Phone ☐ Text ☐ E-mail ☐

Preferred method of confidential contact: (appointment or financial details) primary phone ☐ secure email ☐ letter ☐

Marital Status: Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced ☐ Widowed ☐

Race: White ☐ Hispanic or Latino ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Primary Language: _______________________________

Primary Insurance

Carrier Name ____ Subscriber ____________________________________

Subscriber Birth Date ____/____/____ Relationship to patient ___________________ Effective Date _____/_____/_____

Insurance ID # ____ Group # ______________________________________

Secondary Insurance

Carrier Name ____ Subscriber ____________________________________

Subscriber Birth Date ____/____/____ Relationship to patient ___________________ Effective Date _____/_____/_____

Insurance ID # ____ Group # ______________________________________

Tertiary Insurance

Carrier Name ____ Subscriber ____________________________________

Subscriber Birth Date ____/____/____ Relationship to patient ___________________ Effective Date _____/_____/_____

Insurance ID # ____ Group # ______________________________________

Responsible Party Information (complete this section only if someone other than the patient is financially responsible)

Last ______________________________ First _______________________ Middle___________ Birth Date ____/____/____

M ☐ F ☐ Relationship to Patient _________________________ Primary Phone ____________________ Cell/home/work

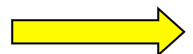
Mailing address ____ Apt # _______________

City ____ State_______________________ Zip __________________

Emergency Contact (Emergency contact must be over the age of 18)

Last ____ First ___________________________ Middle_____________________

Primary Phone _________________________ Cell/Home/Work Alt Phone ______________________ Cell/Home/Work



How did you hear about us?

_____ Angie's List

_____ Facebook

_____ Yelp

_____ Google/Bing/Yahoo

_____ Citysearch

_____ ZocDoc

_____ Referring Physician ______________________________

_____ CDLS Mailer or Event

_____ E-mail Blast

_____ Yellow Pages/Directories

_____ Local Ads

_____ Friend/Referral

_____ Prior Practice

_____ Other ______________________________________

Do you wish to receive e-mails regarding dermatology updates & promotions? Yes ☐ No ☐

I consent to disclose:

(This authorization is of a personal nature-family or friend. Please check all that apply or choose no authorization)

Medical information (example: check on prescriptions, receive test results or discuss a diagnosis)

Appointment information (example: schedule, cancel move or inquire about an appointment)

No authorization to disclose to anyone

To: ____ Relationship: ____

AUTHORIZATION AND CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY

I hereby authorize Center for Dermatology & Laser Surgery to provide medical services to the above-named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign Center for Dermatology and Laser Surgery all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of visit will result in additional charges. I have been offered a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

____ _____/_____/_____

Patient or Responsible Party Signature **Date**