CENTER FOR DERMATOLOGY & LASER SURGERY

Patient Information (Please use your legal name)

Last _____ First _____ Middle_____

Nickname_____ Birth Date ____/____/____ Gender: male / female / non-binary / transgender

SS# _____ Birth Sex: M ☐ F ☐ Pronouns: he/him she/her they/them

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 ____/____/____

Birth Sex: M ☐ F ☐ Gender: _____ Pronouns: _____ Relationship to Patient _____

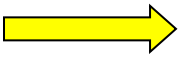
Mailing address _____ Apt # _____ City _____

State_____ Zip _____ Primary Phone _____ Cell/home/work

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**