

Patient Information as of _____
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

_____ Last _____ First _____ Middle _____

Address

_____ Street & Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact _____
Restrictions: _____ **How were you referred to us?** _____

Age _____ Birthdate _____ SS# _____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Primary Care Physician _____ Phone _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____

_____ Street & Suite # _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____

Insured: Name _____ DOB _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____

Insured: Name _____ DOB _____

I assign directly to Dr. David A. Amato all benefits payable for services rendered. I authorize Dr. Amato to release any information necessary to secure payment of said benefits for Highmark Blue Shield, Capital Blue Cross, Geisinger and Medicare patients only and all Medicare supplemental insurance's, and to use this signature on all insurance submissions whether manual or electronic.

I acknowledge that co-payment is due at the time of treatment if I am not a Medicare Patient, unless other arrangements have been made.

I acknowledge that if my insurance carrier is not listed above, I am responsible for payment in full for office visits and procedures.

I agree that the presenting parents/guardians are responsible for all fees and services rendered for treatment of a minor/child.

I accept full financial responsibility for all charges not covered by insurance and agree to make arrangements for prompt payment.

The undersigned verifies that an attempt was made to deliver a copy of the Community Dermatology's Notice of Privacy Policies to the above patient. The undersigned also verifies the Privacy Policy, Financial Policy, and Personal Health Information.

I hereby give my permission to Community Dermatology to disclose my personal health information to the personal representative(s) indicated below:

Name/Relationship _____ Name/Relationship _____

Signature _____ Witness _____