

Patient Information as of \_\_\_\_\_ (date)
(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 \_\_\_\_\_ How were you referred to us? \_\_\_\_\_
Restrictions: \_\_\_\_\_

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

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 \_\_\_\_\_