Patient Information

Last Name _____ First Name: _____

Date of Birth: ____/____/____ Age: _____ Social Security # _____ Sex: Male Female

Full Address: _____

City State Zip

Home Phone #: _____ Mobile Phone#: _____

Work Phone #: _____ E-mail: _____

Marital status: Single Married Divorced Widowed Other

Race: White African American Asian/Pacific Islander Native American
Hispanic Other (Specify_____)

Preferred Language: English Russian Spanish Other _____

Future appointments will be confirmed via TEXT, unless otherwise requested.

Parents Information *(for patient's under age 18)*

Name_____ Date of Birth: _____/_____/_____
Last First M.I.

Address: _____

City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Insurance Information

Company Name:_____ Relationship to Patient: SELF SPOUSE PARENT OTHER

Policy Holder: _____ Policy ID#_____ _____
Last First

Policy Holder Date of Birth:_____/_____/_____ SS #: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed Other

Referred by: ___Doctor (name_____) ____ Family/Friend ____Insurance ____Zoc Doc ____ Internet

____ Newspaper ____ Other (Specify_____)

Primary Care Physician: _____Phone:_____

Pharmacy Name: _____Phone: _____

Pharmacy Address: _____

Emergency Contact Name: _____ Relationship:_____

Phone Number: _____

Acknowledgement of HIPAA notice of privacy practices

I hereby acknowledge that I have fully reviewed and/or have received a complete copy of the HIPAA notice of privacy practices provided by the staff of this office.

Medicare / Medicaid Assignment of Benefits

I certify that the information given by me in applying for payment is correct. I authorize release of all records upon request. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefit

I hereby authorize direct payment of medical benefits to [Adult & Pediatric Dermatology/Michael Paltiel MD PC] for services rendered by all medical providers in the corporation. I understand that I am financially responsible for any balance if my insurance is invalid and I am responsible for copays, remaining balances, deductibles, co-insurance payment, as well as any cosmetic procedures not covered by insurance.

_____ Self Parent Guardian _____

PATIENT or Guardian Signature Relationship to Patient (Circle One) Date