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: _____

Preferred Language: English Russian Spanish Other: _____

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

Insurance Information

Insurance Company Name:_____ Relationship:: 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:_____ ____ Family/Friend ____Insurance ____Zoc Doc ____ Internet

____ Newspaper ____ Other: _____

Primary Care Physician: _____ Phone:_____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Emergency Contact Name: _____ Phone: _____

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.

_____ _____

Patient or Parent Signature Date