Inland Dermatology Skin Care Center

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Patient Information

New Patient:____ **Name Change:**_____ **Address Change:**_____ **Insurance Change:**_____

THIS SECTION MUST BE COMPLETE FOR ALL PATIENTS: **Today's Date:**__/__/__

Patient Name:_____

Last Name *First* *M.I.*

Date of Birth:__/__/__ **Age:**_____ **Sex:** Male____ Female____ **SS#:**_____

ADDRESS:

Mailing Address:_____ **City:**_____ **State:**____ **Zip Code:**_____

Home Phone: ( )_____ **Work Phone:** ( )_____

Cell Phone: ( )_____ **email:**_____

PARENT, SPOUSE, OR RESPONSIBLE PARTY ***(if different from patient)***

Name:_____ **Date of Birth:**__/__/__

Last Name *First* *M.I.*

Address:_____ **City:**_____ **State:**____ **Zip Code:**_____

Home Phone: ( )_____ **Work Phone:** ( )_____

Cell Phone: ( )_____ **email:**_____

INSURANCE COVERAGE – PRIMARY:

Insurance Company Name:_____ **Phone Number:**_____**ext:**_____

Address of Claim Center:_____

_____

Name of Policy Holder *(Insured)*:_____

Policy Holder *(Insured)* Date of Birth:__/__/__ **SS#:**_____ **Sex:** *Male*____ *Female*__

Policy #:_____ **GROUP Name or #:**_____

Policy Type: *HMO*_____ *PPO*_____

Employer Name:_____

Employer Address:_____

If patient is a child, please check relationship: **Mother:**_____ **Father:**_____ **Other:**_____

INSURANCE COVERAGE – SECONDARY

Insurance Company Name:_____ **Phone Number:**_____**ext:**_____

Address of Claim Center:_____

_____

Name of Policy Holder *(Insured)*:_____

Policy Holder *(Insured)* Date of Birth:__/__/__ **SS#:**_____ **Sex:** *Male*____ *Female*_____

Policy #:_____ **GROUP Name or #:**_____

Policy Type: *HMO*_____ *PPO*_____

Employer Name:_____

Employer Address:_____

If patient is a child, please check relationship: **Mother:**_____ **Father:**____ **Other:**_____

REFERRED BY:_____**Attach Both Sides of Patient's Insurance Cards**

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY and SIGNATURE ON FILE

Patient Name:_____ **Today's Date:**____/___/____

Other family members that are patients:_____

Primary Care Physician:_____ Phone: (___)_____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified?_____ Phone: (___)_____

Do you give our office permission to discuss your medical information with Family Members?

YES____ NO____

If yes, please provide their names and phone numbers below:

Name:_____ Relationship:_____

Phone *(day)*:_(___)_____ Phone *(evening)*: (___)_____

May we leave medical information on your answering machine at home? YES__ NO__

May we email personal medical information to you? YES_____ NO_____

Email address:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have read and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I Have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature:_____ Date:___/___/___

PAYMENT POLICY:

HMO, PPO or Other Managed Care Patients: *You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.*

Commercial Patients: *Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay a 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of you carrier.*

Patient or Responsible Party Signature:_____ Date:___/___/___