PATIENT INFORMATION

DATE_______________________

NAME____
(First) (MI) (Last)

ADDRESS____
(Street) (Apt)

____
(City) (State) (Zip)

HOME #( ) _______________ WORK #( ) ________________ CELL #( ) _____________________

MAY WE LEAVE MESSAGES AT THESE NUMBERS? HOME WORK CELL (Circle all that apply)

SOCIAL SECURITY# ________________________ MARITAL STATUS_______________SEX_____________

BIRTHDATE______________________ AGE_____________

EMPLOYER___________________________________OCCUPATION___________________________________

RESPONSIBLE PARTY (FOR THIS SECTION ONLY –TO BE COMPLETED IF YOU ARE COVERED UNDER A SPOUSE/PARENT'S PLAN OR IF PATIENT IS A MINOR)

NAME____

ADDRESS____
(Street) (Apt)

____
(City) (State) (Zip)

HOME#________________________ WORK# ____________________ CELL#___________________________

SOCIAL SECURITY# ___________________________

BIRTHDATE_________________MARITAL STATUS______________SEX___________ AGE_______________

EMPLOYER____________________________________ OCCUPATION__________________________________

PATIENT RELATIONSHIP: SPOUSE - DEPENDENT - OTHER (Circle)

REFERRED BY

REFERRING PHYSICIAN____________________________________ PHONE#__________________________

FRIEND__________________________ INTERNET SITE_________________________YELLOW PAGES_______

OTHER___________________________________

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME____ PHONE#__________________________

EMERGENCY INFORMATION

(MUST BE FILLED OUT)

CONTACT____
(NAME) (PHONE #) (RELATIONSHIP)

MEDICAL INFORMATION

CURRENT MEDICATIONS____

ALLERGIES TO MEDICATIONS____

DISEASES/ILLNESS____

INSURANCE INFORMATION

PRIMARY INS_______________________________SECONDARY INS_____________________________________

I ACKNOWLEDGE THE ABOVE INFORMATION TO BE TRUE AND ACCURATE. I AUTHORIZE THE RELEASE OF RECORDS NECESSARY TO ASSIST IN THE REIMBURSEMENT OF BENEFITS TO WHICH I MAY BE ENTITLED AND TO REFERRING PHYSICIANS OR OTHER HEALTH CARE PROVIDERS IN PROVIDING TREATMENT OF THE PATIENT.

I AUTHORIZE THE PAYMENT OF MEDICARE/OTHER INSURANCE COMPANY BENEFITS TO DOWNTOWN DERMATOLOGY, P.A. AND/OR SHELDON L. MANDEL, MD FOR SERVICES PROVIDED. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CHECK WITH MY INSURANCE REGARDING ANY REFERRALS OR PRIOR AUTHORIZATIONS. I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. IN THE EVENT YOUR ACCOUNT IS TURNED OVER TO OUR COLLECTION AGENCY, ASSET RESOURCES INC., FOR NON-PAYMENT, THERE WILL BE AN ADDITIONAL CHARGE OF 35% OF YOUR UNPAID BALANCE.

SIGNATURE____ **DATE**_______________