



<i>Administrative Use Only</i>	
New Patient <input type="checkbox"/>	Current Patient <input type="checkbox"/>
Provider _____	

PATIENT INFORMATION SHEET

Please bring your insurance card to your appointment

Date _____

Patient Name _____ Date of Birth _____ Gender M F
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 E-mail address _____ I do not have an email
 Emergency Contact _____ Relationship _____ Phone Number _____

Do you want to be on our e-mail list for new office developments, newsletters, etc.? Yes No
 How did you hear about our practice? Physician Friends/Family Radio Website

Please give us the following information to facilitate our communication with your primary care physician

Primary Care Name (first and last) _____ City _____
 Did your doctor give you a referral for this visit? Yes No
 Social Security Number _____
 Primary Insurance _____ ID # _____ Group # _____
 Cardholder Name _____ Cardholder D.O.B. _____ Relationship _____
 Secondary Insurance _____ ID # _____ Group # _____
 Cardholder Name _____ Cardholder D.O.B. _____ Relationship _____

I have been able to review the Dermatology Partners Notice of Privacy Practices (available in our office). This notice provides information about how Dermatology Partners may use and disclose my protected health information, what its legal duties are regarding my protected health information, what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Dermatology Partners for clarification.

By signing below, I also hereby authorize my insurance benefits (if applicable) to be paid directly to Dermatology Partners, Inc. I realize that I am responsible for the payment of non-covered services, co-payments, and deductibles. I also authorize the release of pertinent information to insurance carriers.

Patient Signature _____ Date _____