PATIENT INFORMATION

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 _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

RACE _____ ETHNICITY _____

REFERRED BY

REFERRING PHYSICIAN _____ PHONE# _____

FRIEND _____ INTERNET SITE _____

OTHER _____ YELLOW PAGES _____

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME _____ PHONE# _____

EMERGENCY INFORMATION
(MUST BE FILLED OUT)

CONTACT _____
(NAME) (PHONE #) (RELATIONSHIP)

MEDICAL INFORMATION

CURRENT MEDICATIONS _____

_____

PHARMACY INFORMATION

_____
(NAME) (ADDRESS) (PHONE)

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 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** _____

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