

## **New Patient Instructions**

**Dermatology Affiliates, PC**

1. Please arrive 20 minutes early for your first appointment to allow time for us to prepare your chart.
2. You may print and fill out the "Patient Registration Form" in advance to save some time. You will be able to review our privacy policy when you arrive. If you prepare the form ahead of time, remember to bring the original with you because we need original signatures.
3. In addition, please bring to your visit:
  - a. Your Insurance Card
  - b. A Picture ID
  - c. If under 18, the patient must be accompanied by a guardian
  - d. A method to pay charges not covered by your insurance. We accept checks, American Express, Visa, MasterCard, Discover & cash though we can not make change for bills larger than \$20.

**PLEASE SEE PAGE 2 FOR THE PATIENT REGISTRATION FORM**

Thank you and we look forward to seeing you!

**Dermatology Affiliates, P.C. – Patient Registration – Please Fill In Completely**

**PATIENT INFORMATION:**

Preferred name to be called: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M F  
First Middle Last

Date of Birth: \_\_\_\_\_ Marital Status: S M D W Social Security Number: \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ Relation \_\_\_\_\_ PH# \_\_\_\_\_

**PLEASE LIST:**

**Allergies:**(To Medications &/or Medical Products) \_\_\_\_\_

**Medications:**(Currently Taking) \_\_\_\_\_

**GUARANTOR OR RESPONSIBLE PARTY (Patient is Responsible Party if OVER 18 Years of Age):**

Name: \_\_\_\_\_ Sex: M F  
First Middle Last

Date of Birth: \_\_\_\_\_ Marital Status: S M D W Social Security Number: \_\_\_\_\_

*IF DIFFERENT FROM ABOVE:*

Address \_\_\_\_\_  
City State Zip

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE INFORMATION: (Please Complete if Patient is Not Policy Holder)**

PRIMARY INSURANCE:

Policy Holder's Name \_\_\_\_\_ SSN \_\_\_\_\_  
First Middle Last

Relationship to Patient: Spouse Child Parent Grandparent Grandchild Sibling Life Partner

Sex: M F DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

SECONDARY INSURANCE:

Policy Holder's Name \_\_\_\_\_ SSN \_\_\_\_\_  
First Middle Last

Relationship to Patient: Spouse Child Parent Grandparent Grandchild Sibling Life Partner

Sex: M F DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

**REFERRING DOCTOR:** \_\_\_\_\_ PH#: \_\_\_\_\_ Primary Dr. \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?** Friend \_\_\_\_\_ Ins. Internet Other \_\_\_\_\_

**PRIVACY PRACTICES NOTICE & WRITTEN ACKNOWLEDGEMENT FORM**

*I have been offered a copy of DERMATOLOGY AFFILIATES, P.C.'S Notice of Privacy Practices.*

Signature of Patient/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION**

*I request payment of authorized insurance benefits be paid to DERMATOLOGY AFFILIATES, P.C. & authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.*

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_