

MID-COUNTY DERMATOLOGY, INC

NEW PATIENT INFORMATION

Referred by _____

Name _____ Sex _____ Birthdate _____ Marital Status (S,M,D,W) _____
Last First M.I.

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell Phone _____

May we leave a message on your answering machine / Voicemail? Yes / No

Social Security# _____ Employer _____ Occupation _____

Are you now pregnant? Yes / No Allergic to any medications? Yes / No Please list: _____

Current Medications _____

Known medical and surgical problems (cancer, diabetes, heart, etc.) _____

Skin problem and location _____ How long? _____

In case of Emergency please notify: _____ Phone _____

Insurance Card Holder / Subscriber Information : Self, Spouse, Parent, Other _____

Name _____ Social Security# _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____

Please be prepared to present insurance card(s) to the receptionist at time of your visit! The receptionist will make a copy and return card(s) to you promptly.

Mid-County Dermatology, Inc HIPPA Privacy Act (a full copy of our privacy act is available upon request)

- ▶ Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- ▶ Mid-County Dermatology, Inc has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- ▶ Mid-County Dermatology, Inc reserves the right to change the Notice of Privacy Practices.
- ▶ The patient has the right to restrict the uses of their information but Mid-County Dermatology, Inc does not have to agree to those restrictions.
- ▶ The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- ▶ Mid-County Dermatology, Inc may condition the receipt of treatment upon the execution of this consent.

This consent was signed by: _____

Patient Name

Signature

Relationship to patient

Date

I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or for that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment of my account within a reasonable period of time.

Signature of responsible party

Date