MID-COUNTY DERMATOLOGY, INC

NEW PATIENT INFORMATION

PHARMACY # ________________

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 no 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