EASTERN DERMATOLOGY AND PATHOLOGY

(Please Print)

NAME:____
First **MI** **Last**

DATE OF BIRTH: _____/_____/_____ AGE:________________SEX:________________

MAILING ADDRESS:____
Street Name and Number of PO Box **City** **State** **Zip**

HOME PHONE: ( )_____-________ WORK PHONE: ( )_____-________ SS#______-_____-______

CELL NUMBER: ( )_____-________ **(Please include area codes for all phone numbers)**

MARITAL STATUS: **S=single** **M=married** **D=divorced** **W=widowed** **(Circle the one that best describes you current status)**

DID ANOTHER DOCTOR REFER YOU? YES NO (WHOM)________________________________

NAME OF PRIMARY CARE DOCTOR:________________________________

NAME OF PHARMACY:________________PHONE: ( )_____-________ and/or LOCATION:____________
(Please include area code.)

EMERGENCY CONTACT:__________________RELATION:____________PHONE:( )_____-______
(Please include area code.

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD(S) AT TIME OF CHECK IN.)

******PLEASE NOTE******

We are glad to file insurance for you and will do so in a timely manner. However, to do so, the following information needs to be given in its entirety. Any incomplete information will result in us not being able to file your insurance claims and you will be given the option to either pay in full for services rendered on the day of your visit or to reschedule your appointment.

PRIMARY INSURANCE
(The insurance that is filed first.)

INSURANCE NAME:________________________

SUBSCRIBER'S NAME:________________________
(Policy holder. Person to which the insurance is issued.)

SUBSCRIBER'S DATE OF BIRTH:________________

SUBSCRIBER'S ID#:________________________

GROUP#:________________________

SUBSCRIBER'S EMPLOYER

____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:

____

SECONDARY INSURANCE
(The insurance that is filed second.)

INSURANCE NAME:________________________

SUBSCRIBER'S NAME:________________________
(Policy holder. Person to which the insurance is issued.)

SUBSCRIBER'S DATE OF BIRTH:________________

SUBSCRIBER'S ID#:________________________

GROUP#:________________________

SUBSCRIBER'S EMPLOYER

____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:

____

(Please complete reverse side)

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your home answering machine/voice mail/family member?	**YES**	**NO**
Leave a message at your place of employement?	**YES**	**NO**

I hereby assign, and set over to **Eastern Dermatology and Pathology** all of my rights and interests to my medical reimbursement benefits under my Medicare or any other government agency or private insurance policy. I authorize Eastern Dermatology and **Pathology** to perform any services necessary for proper treatment. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance (including deductibles, co-insurance and non-covered medical procedures).

______________________ ______________________ ______________

Patient's Signature **Guardian's** Signature Date

CONSENT FOR RELEASE OF

PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care: ______________________

____

____

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of Eastern Dermatology & Pathology, PA unless and until I notify Eastern Dermatology & Pathology, PA in writing of any changes.

______________________ ______________________

Signature of Patient or Representative Date

____

Print Name

____

Relationship of Representative to Patient

Eastern Dermatology & Pathology PA

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of **Eastern Dermatology & Pathology, PA's** Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

__________________________________ __________________________________

Signature of Patient or Representative Date

____

Print Name

____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient:____________________________

____

____

FOR **Eastern Dermatology & Pathology, PA** USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

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