□ *New Patient* □ *Returning Patient* □ *Ins. Change* □ *Address Change* □ *Name Change*

FAYETTE AREA DERMATOLOGY

Patient Information

Patient Name: _____

Marital Status: □ Single □ Married □ Widowed □ Separated SS#_____

DOB: _____/_____/_____ Birth Sex: □ Male □ Female

Primary Care Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone:_____

Emergency Contact Information

Name: _____ Relationship: _____ Phone#:_____

Parent, Spouse, or Responsible Party Contact Information

Name: _____ Relationship: _____ Phone#: _____

SS#_____ Work#_____

Address: _____ City: _____ State: ____ Zip Code:_____

Patient Contact Information

Home # _____ Cell # _____ Work #_____

Preferred Contact Method: □ Home □ Cell □ Work □ Other: _____

Email Address: _____

Home Address: _____ City: _____ State: ____ Zip Code: _____

PRIMARY INSURANCE COVERAGE **PLEASE PROVIDE YOUR CURRENT INSURANCE CARD**

Insurance Co Name: _____ Policy# _____ Group#_____

Policy Type: □ PPO □ POS □ HMO □ Medicare □ Other:_____

Insured's Name (*Policy Holder*) _____ Relationship:_____

DOB: _____/_____/_____ SS#_____ Phone #_____

Company Name:_____

SECONDARY INSURANCE COVERAGE **PLEASE PROVIDE YOUR CURRENT INSURANCE CARD**

Insurance Co Name: _____ Policy# _____ Group#_____

Policy Type: □ PPO □ POS □ HMO □ Medicare □ Other:_____

Insured's Name (*Policy Holder*) _____ Relationship:_____

DOB: _____/_____/_____ SS#_____ Phone #_____

Company Name:_____

Authorization for Release of Information

I authorize Fayette Area Dermatology to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. I understand I have the right to revoke this authorization at any time. I understand I have the right to refuse to sign this authorization.

If you would like for us to do any of the following, please initial and sign below.

_____OK to leave message on answering machine regarding medical/financial info
_____OK to leave message with spouse regarding medical/financial info
_____OK to leave message with _____ regarding medical/financial info

Patient Signature _____ Date_____