Advanced ✷ Dermatology
111 Salem Turnpike, Suite #7
Norwich, Connecticut 06360

Patient Demographic Information

Patient's Name: ____Date of Birth:________________
Race/Ethnicity:______________ Language:____________Employer: _______________________

Address: ___________________________City:_________________ State:_____Zip: ___________

Home #: ________________________________Cell #: ________________________________

Family MD____________________________Referring MD________________________________

Preferred Pharmacy/Location:_____________________________/_________________________

Primary Insurance :_____________________________Policy Holder:___________________

Relationship to Patient:_______________SS#:__________________Date of Birth:_________

Secondary Insurance:____________________________ Policy Holder:___________________

Relationship to Patient:_______________SS#:__________________Date of Birth:_________

Please list any spouse, family member, caregiver, and/or friend who Advanced Dermatology can speak with regarding your care, biopsy results, appointments, etc.

Name:____Your Initials:__________

Emergency Contact:____________________________________Tele #:______________________

History Update

Reason for today's visit:_______________________________ Allergies to Medications: Y N
If Yes, please list medication allergies____
Daily Medications: Are you attaching a list? Y N ________________________________

____

Do you require antibiotics before undergoing dental procedures? Y N
Have you been previously diagnosed with, treated for or received any of the following:

Artificial joints	Y	N	AIDS/HIV Infection	Y	N
Artificial Heart Valve	Y	N	Bleeding Disorder/Tendency	Y	N
Heart Murmur	Y	N	Kidney Disease	Y	N
Internal Defibrillator	Y	N	Liver Disease	Y	N
Pace Maker	Y	N			

Please list any other illnesses, surgeries, hospitalizations and dates (Recent within the last year)

____

Completed by/ Signature: ____ Date:_____________

Advanced ✷ Dermatology
111 Salem Turnpike, Suite #7
Norwich, Connecticut 06360

Release of Information and Authorization of Benefits

Patient Name:____Account #:_______________

I authorize Advanced Dermatology, L.L.C. to release medical information, or anything pertaining to the examination, treatment, history, and medical expenses including preexisting condition information to my insurance companies and/or its acting intermediary or agent, or employer/compensation carrier(s), or its legal representative for the purpose of processing insurance claims. This release may include reviewing and/or photocopying pertinent documents for the purpose of payment by your insurance company.

I authorize release of medical information to physicians or health practitioners (for example, Physical therapists) to whom I may be referred.

I authorize payment of medical insurance benefits* to be made directly to Advanced Dermatology, L.L.C. I permit a copy of this authorization to be used in place of the original.

I understand that it is my responsibility to ensure Advanced Dermatology, L.L.C. participates with my insurance. Advanced Dermatology requires a 24-hour advanced cancellation notice, failure to notify the office will result in a $25.00 no show fee effective June 1, 2004.

I agree to accept full financial responsibility for payment of charges for services rendered. I further agree to pay the cost of collections and/or attorney's fees in the event this account is referred to a collection agency or attorney.

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with an effective date of June 1, 2004.

____
Patient or Guarantor Signature Date

____
If guarantor, indicate relationship to patient

*For Medicare patients, this applies to The Social Security Administration or its intermediaries, or carriers. *For Blue Shield of Connecticut, this applies to a covered service rendered by a participating physician only.