Advanced ✷ Dermatology

111 Salem Turnpike, Suite #7
Norwich, Connecticut 06360

Patient Demographic Sheet

Date:____________________

Patient's Name: _________________________Gender:_________Marital Status: S M W D

Date of Birth:_____________Height:____________Weight:__________________

Address: _____________________________City:____________________ State:_______ Zip: ________

E-mail:________________________Race/Ethnicity:__________________ Language:_________

Tele #: Primary: ____________________________Cell #: ______________________________

Employer: ____

Family MD/Address: ______________________________/______________________________

Referring MD/Address:_________________________________/_____________________________

Preferred Pharmacy/Location:_____________________________/_____________________________

<u>PLEASE FILL IN ALL INSURANCE INFORMATION BELOW**</u>**

Name of <u>Primary</u> Insurance:____

Identification#:__________________________________Group#______________________________

Name of person who holds the insurance policy:________________________________

Relationship to Patient:_________SS#:____________________Date of Birth:_______

Name of <u>Secondary</u> Insurance Company:_____________________________________

Identification#:__________________________________Group#______________________________

Name of person who holds the insurance policy:________________________________

Relationship to Patient:_________SS#:____________________Date of Birth:_______

**** <u>Parent/Guardian: Name and Address (if different than above)</u> ****

Name:____
Address:____Tele #:__________________

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

If we may only speak with you, please cross this section out

Name:____Your Initials:_______

Emergency Contact: ____________________________________ Tele #:_____________________________

<u>Advance Care Planning</u>

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes or No

If yes: Name: ____Tele #:_____________________________

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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.

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Patient or Guarantor Signature Date

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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.