

MONTGOMERY DERMATOLOGY, LLC

PATIENT INFORMATION

TODAY'S DATE: _____

PLEASE CIRCLE ONE: New Patient Name Change Address Change Insurance Change

Name _____

Date of Birth: ____/____/____ Age: ____ Sex: Male Female SS# _____

Mailing Address _____

City State Zip

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ e-mail: _____

Preferred phone line to receive confirmation calls for appts: (Please circle) Home / Work / Cell

Preferred phone line to receive biopsy/test results? (Please circle) Home/ Work / Cell

PHARMACY NAME & PHONE NUMBER : _____

Emergency Contact: Name: _____ Phone number _____

Primary care physician Name/Address/ Phone Number: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ____/____/____

Address: _____

Home Phone: () _____ Work Phone:() _____

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____

Subscriber's Relationship to patient: Self _____ Spouse _____ Parent _____ Other _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Subscriber's Address: _____

Subscriber's Place of Employment: _____ Subscriber's Work Phone: _____

Secondary Insurance Carrier: _____

Subscriber's Relationship to patient: Self _____ Spouse _____ Parent _____ Other _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Subscriber's Address: _____

Subscriber's Place of Employment: _____ Subscriber's Work Phone: _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to my dependents or to me. I also understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary, or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or to me. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

X _____

Signature of Patient or
Parent/Relation Representative

Print Name of Patient or
Personal Representative

Date

I acknowledge that I have received a copy of this office's **NOTICE OF PRIVACY PRACTICES (HIPAA Rules)**. I consent to the use and disclosure of my medical information to treat me and arrange for my medical care, to seek and receive payment for the services given to me, and for the business operations of this medical office.

X _____

Signature of Patient or
Parent/Relation Representative

Print Name of Patient or
Personal Representative

Date

Please provide your insurance card(s) and driver's license to the receptionist along with this form

How did you hear about our practice? _____