PATIENT INFORMATION

Birth Date_____/_____/_____

Patient's Full Name _____ Preferred Name _____
(First) (Middle) (Last)

Patient's Address_____

Age _____ Sex _____ Social Security # _____ Home Phone _____

Occupation _____ Work Phone _____

Employer _____ Email Address _____

Spouse _____ or, if applicable, Parent _____

Responsible Party (if patient is under 18) _____ Relationship _____

Responsible Party's Address _____ Home Phone _____

Responsible Party's Social Security # _____ Work Phone_____

HEALTH INSURANCE INFORMATION

Medicare? Yes_____ No _____ If yes, Medicare #_____

Health Insurance _____ Policy # _____ Group # _____

Name of Insured (if other than patient) _____

Insured's Social Securtiy # _____ Insured's Date of Birth: _____

Insured's Employer _____ Employer Phone _____

Billing and Insurance Policy: All professional services rendered are charged to the patient. The Patient will be expected to pay for services when rendered **unless other arrangements have been made in advance.** This office does not file for outpatient services unless contracted.

Insurance Authorization: I hereby authorize Raleigh Dermatology Associates, P.A. to furnish information to insurance carriers concerning all illness and treatments. I hereby assign to the physician all payments for medical services rendered to myself if assignment is accepted by said physician in the event insurance is filed for myself or my dependents. I understand that I am responsible for any amount not covered by insurance. A copy of this signature is as valid as original.

Signature _____ Date _____

REASON FOR VISIT

Problem _____ When did symptoms first appear? _____

Is problem related to a specific injury? Yes _____ No _____ If yes, date of injury _____ / _____ / _____

Please explain how injury occurred and where _____

Are you allergic to any medications? Yes _____ No _____ Please list:_____

Full Name and Address of Referring Physician _____

_____