PATIENT INFORMATION FORM

Please Select: □ **New patient** □ **Address Change** □ **Name Change** □ **Insurance Change**

Patient Name:____ Date of Birth:______/______/______

Sex: □ Male □ Female Age: ________ Social Security #________________________ Marital Status (Circle): M S D W

Mailing Address:____

Home Phone: ( )__________________________ Work Phone: : ( )____________________________

Cell Phone: : ( )__________________________ Email:____

Employer: ____ Occupation: __________________________________

Parent, spouse, or responsible party (if different from patient):

Name:____ Date of Birth____/____/____

Address:____

Home Phone: ( )__________________________ Work Phone: ( )____________________________

HOW WILL YOUR VISIT BE COVERED TODAY? □ **INSURANCE** □ **SELF PAY**

Insurance Coverage- Primary:

Insurance Company Name:____

Name of Policy Holder (Insured):____

Policy Holder (Insured) Date of Birth: ______/______/______ Policy Type: □ HMO □ PPO

Policy #:______________________________________ Group Name or #:___________________________

If patient is a child, check relationship to insured □ Mother □ Father □ Other ___________________________

Insurance Coverage- Secondary:

Insurance Company Name:____

Name of Policy Holder (Insured):____

Policy Holder (Insured) Date of Birth: ______/______/______ Policy Type: □ HMO □ PPO

Policy #:______________________________________ Group Name or #:___________________________

If patient is a child, check relationship to insured □ Mother □ Father □ Other ___________________________

By signing below, 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 permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or the party who accepts assignment. I authorize Intracoastal Dermatology to provide any and all information to the above-named insurance companies to obtain payment for the evaluation and treatment provided.

Signature____ Date ____/____/____

HOW WOULD YOU LIKE US TO CONTACT YOU FOR APPOINTMENT REMINDERS? □ Call □ Text □ Email

In case of emergency, who should be notified? ______________________________ Relationship: __________________

Phone: ( ) ______________________

HOW DID YOU HEAR ABOUT US?

□ Current Patient: ____

□ Event/Promotion: ____

□ Primary Care Physician: ____________________________________ Phone: ( ) _____________________

□ Other: ____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?
(Per HIPAA regulations, we cannot discuss your health information with anyone but you unless otherwise indicated below, including spouses. This includes billing information as well.)

□ YES □ NO If yes, please provide their names and phone numbers below:

Name:___________________________________	Name:___________________________________
Relationship:______________________________	Relationship:______________________________
Day phone: ( )_________________________	Day phone: ( )_________________________
Evening phone: ( )______________________	Evening phone: ( )______________________

ACKNOWLEDGEMENTS

RECIEPT OF NOTICE OF PRIVACY PRACTICES. My signature indicates I have received and/or reviewed a copy of my Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

PATIENT PAYMENT RESPONSIBILITIES. I understand if I am uninsured or have an insurance that is not accepted at the practice, I will be responsible for payment in full at the time of service. I understand insurance copays, deductibles, co-insurance and charges not filed with insurance are due at the time of service. Failure to make payment when requested is a basis for legal action, and the undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State of Florida and any other state. **I understand that I will be responsible for ANY charges that are not paid by my insurance company. I understand that it is my responsibility to know the limits of my coverage and to pay any fees that my insurance company denies.** (As a service to you, our staff will bill your insurance carrier, but if you do not pay your balance in a timely fashion, we will ask

that you pay in full at your visits and file your own claims.) I understand that procedures may fall under major medical, therefore I will be responsible for paying the deductible amount at the time of service. Procedures include treatment of skin lesions (including warts, molluscum, moles, tags, precancers, skin cancers) by ANY method (including freezing, biopsy and in-office application of medication).

CONSENT TO TREATMENT AND PHOTOGRAPHY. I consent to the evaluation and treatment by the physicians and medical staff at Intracoastal Dermatology. I understand that the treatment and evaluation of dermatologic conditions involves the examination of the skin on all parts of the body. I consent to necessary treatment, including drug, medicines, performance of operations and conduct of studies that may be conducted by Intracoastal Dermatology. I am aware that the practice of medicine, is not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services. I consent to Intracoastal Dermatology taking photographs of my skin, for treatment, evaluation and "before and after" comparison purposes only. I understand these photos will remain in my medical chart unless otherwise directed by me.

Please initial next to the appropriate statement(s):

_________ My photos will only be used for my chart.

_________ I give permission for my photos to be used for education. Under no circumstances will publications bear your name or identity, unless voluntarily disclosed by you.

_________ I give permission for my photos to be used for marketing and advertising purposes. Under no circumstances will publications bear your name or identity, unless voluntarily disclosed by you.

Signature____ Date ____/____/____

If you have not done so already, please present your insurance card(s) and photo ID to the receptionist along with your completed forms.

Thank you for trusting us with your dermatologic care! We look forward to serving you.