PATIENT ANNUAL UPDATE

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Welcome to our office!

The information you provide below is confidential and for our records.
Please print. A larger printed version is available.

Today's Date: _____

Patient's Name: Last_____ First_____
Street Address: _____
City: _____ State: _____ Zip:_____
Phone number: Cell_____ Work_____
Date of birth: _____/_____/_____ Sex: M F Marital Status: M W S D
If married, spouses' name: _____
Race: _____ Ethnicity: _____ Language spoken:_____
Employer: _____ Occupation:_____
Do you work indoors/outdoors?_____
Last four digits of your Social Security#: _____/_____/_____
Email address: _____
Primary Care Physician: _____ Phone: _____
If minor, name of parent or guardian: _____

Insurance Information
Primary insurance: _____
ID#: _____ Group #: _____
Policy holder: _____
Relationship:_____DOB: _____/_____/_____
Secondary insurance: _____
ID#: _____ Group #: _____
Policy holder: _____
Relationship:_____DOB: _____/_____/_____

Emergency contact name: _____ Phone: _____

How did you hear about us?: _____ or
Whom may we thank for your referral to our office?: _____

Reason for today's visit: _____

Our goal at A Center for Dermatology, Cosmetic and Laser Surgery is to provide our patients with quality, affordable healthcare. In order for our medical practice to effectively provide timely healthcare, our office has added a policy to cover the costs that are incurred when appointments are not cancelled in a timely manner. **As of May 1st, 2015, there will be a charge of $50.00 for any appointment that has not been cancelled 24 hours in advance.**

We strive to provide the best care to our patients in an efficient manner. There are a few releases, consents and acknowledgements we have to help provide this care:

- Please notify the staff at A Center for Dermatology of any changes in insurance coverage and address.
- Please bring your insurance card and photo ID to every appointment.
- In accordance with insurance contracts, co-payments and/or deductibles are due at the time the services are rendered.
- Please bring all medication bottles/tubes to your appointment so we may verify correct dosing.
- Allow 24 to 48 hours for prescription refills.
- Due to charges from our bank, there will be a $35-$50 charge on returned checks in addition to the amount of the check.

Please initial below:

_____ I authorize the physicians and assistants to administer medical care as deemed necessary.

_____ I authorize release to my insurance company, any information, including diagnosis and records of any treatment provided.

_____ I authorize and request my insurance company to pay directly to my named physician the amount due on my pending claim.

_____ I acknowledge that I have received Notice of Privacy Practices.

_____ I understand that I am personally responsible for payment of all fees (including deductibles and co-payments) for all procedures and services rendered.

_____ I understand that my health information will not be discussed with anyone other than myself, unless specified in writing. (If you wish to allow us to discuss any information with another party, please ask for a PHI release at the front desk).

It is our policy to notify patients of their results either by phone, email, mail or with a follow up office visit. In the space provided below, please provide a phone number where you can be reached. If we cannot reach you directly and you wish, we will leave a message at that number with your actual test results, and/or with instructions regarding a needed medical office visit follow up. If you do not write in a phone number we will provide you with an office visit to review your results. Phone #: _____

Thank you for allowing our office to provide you with your skincare needs.

Patient or Parent/Guardian Signature: _____

Print Name: _____ Date: _____

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