ORANGE DERMATOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION (*Please Print*)

Name____SS#_______________________
Last *First* *M.I.*

Date of Birth ___/___/___ Age_____ Gender_____ Marital Status______ Occupation______________

Mailing Address____
City *State* *Zip*

Home # ____________________ Cell #________________________ Work # _________________________

Emergency Contact Name/Relationship: ________________________________ Phone #_________________

For Patient Portal Access: Email Address ____
(Are you interested in receiving more information via email about cosmetic procedures and/or promotions? Yes No)

Federal Government Requirement Race_____________ Ethnicity_____________________ Decline

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POLICY HOLDER /RESPONSIBLE PARTY ***(if different from patient)***

Name____SS#_____________________
Last *First* *M.I.*

Date of Birth___/___/___ Gender_______ Marital Status_________ Occupation_________________

Mailing Address____
City *State* *Zip*

Home #_______________________Cell # __________________________ Work #______________________

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

<u>Primary</u> Insurance Name______________________
Name of Insured_____________________________
Insured's ID#___ ___________________________
Employer Name______________________________
Relationship to patient ________________________

<u>Secondary</u> Insurance Name______________________
Name of Insured_______________________________
Insured's ID#__ ______________________________
Employer Name________________________________
Relationship to patient _________________________

PHARMACY NAME, ADDRESS & PHONE# ____
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PRESCRIPTION PLAN ID NO.____

(PLEASE COMPLETE BOTH SIDES)

WE RESPECT YOUR PRIVACY **(Our HIPAA Policy is posted in the office)**

I authorize the release, as necessary, of my medical information, or that of my dependents, to my primary care or referring physicians, or to consultants, or to process insurance claims and prescriptions. I also authorize payment of my medical benefits, whether private or governmental (Medicare), to Orange Dermatology Associates, P.C. for all professional services rendered by their providers to me or my dependents.

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered, including any unmet deductibles, co-payments and non-covered services. If my account is turned over to a collection agency or if I fail to keep a scheduled appointment, a service charge will be added.

To insure patient confidentiality, our office policy is to give test results to the patient only. If we call your home and another member of your household answers the telephone, may we leave results? Yes No
May we leave personal medical information on your answering machine at home? Yes No
May we leave personal medical information on your cell phone? Yes No
May we call your cell phone to confirm your appointment? Yes No

I acknowledge reading this entire page including the posted HIPAA privacy notice.

Patient or Responsible Party (if minor)

Signature____Date___/___/___

Print Name ____