

*Fayette Area Dermatology*

|                            |                          |                            |                            |
|----------------------------|--------------------------|----------------------------|----------------------------|
| <b>Patient Information</b> |                          |                            |                            |
| Patient Name _____         | Birthdate ____/____/____ | <input type="checkbox"/> M | <input type="checkbox"/> F |
| Address: _____             | City _____               | State _____                | Zip _____                  |
| SS# _____                  | Email: _____             | Referring Physician: _____ |                            |
| Home Phone _____           | Cell _____               | Work _____                 |                            |

|                          |                        |                      |
|--------------------------|------------------------|----------------------|
| <b>Emergency Contact</b> |                        |                      |
| <b>Name:</b> _____       | <b>Relation:</b> _____ | <b>Phone#:</b> _____ |

|  |                     |              |           |
|--|---------------------|--------------|-----------|
| <b>Parent, Spouse or Responsible Party (if different from patient)</b> |                     |              |           |
| Name: _____  | Relationship: _____ | Home # _____ |           |
| Date of Birth: _____   | SS# _____           | Work# _____  |           |
| Address: _____   | City _____          | State _____  | Zip _____ |

|   |   |              |  |
|---|---|--------------|--|
| <b>PRIMARY INSURANCE COVERAGE</b>             | <b>PLEASE PROVIDE YOUR CURRENT INSURANCE CARD</b> |              |  |
| Insurance Co Name: _____                      | Policy# _____                                     | Group# _____ |  |
| Insured's Name ( <i>Policy Holder</i> ) _____ | Relationship _____                                | DOB _____    |  |
| SS# _____                                     | Company Name: _____                               | Phone: _____ |  |

|   |                     |              |  |
|---|---------------------|--------------|--|
| <b>SECONDARY INSURANCE COVERAGE</b>           |                     |              |  |
| Insurance Co Name: _____                      | Policy# _____       | Group# _____ |  |
| Insured's Name ( <i>Policy Holder</i> ) _____ | Relationship _____  | DOB _____    |  |
| SS# _____                                     | Company Name: _____ | Phone: _____ |  |

**Authorization for Release of Information**

I authorize Fayette Area Dermatology to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. I understand I have the right to revoke this authorization at any time. I understand I have the right to refuse to sign this authorization.

**If you would like for us to do any of the following please initial and sign below.**

- \_\_\_\_\_ **OK to leave message on answering machine regarding medical/financial info**
- \_\_\_\_\_ **OK to leave message with spouse regarding medical/financial info**
- \_\_\_\_\_ **OK to leave message with \_\_\_\_\_ regarding medical/financial info**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_