SkinSpeaks
Advancements in Dermatology | Spa M.D.

Patient Information

PLEASE PRINT (Fill out completely)

Patient Name: _____ Date of Birth: _____ / _____ / _____
First MI Last MM DD YYYY

Sex: M or F Marital Status: _____ SS #: _____ Language: _____

Address: _____
Street City State Zip Code

Home Phone #: _____ - _____ - _____ Cell #: _____ - _____ - _____ Email: _____

Employer: _____ Work #: _____ - _____ - _____

Race:

- ☐ America Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Ethnicity:

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin

Primary Insurance Information

Insurance Co. Name: _____

Name of Policy Holder: _____

Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance Information

Insurance Co. Name: _____

Name of Policy Holder: _____

Date of Birth: _____

Relationship to Patient: _____

Parent/Guardian Information Presenting With Minor

Name: _____ Date of Birth: _____ / _____ / _____
First MI Last MM DD YYYY

Address: _____
Street City State Zip Code

Relationship to patient: _____ SS #: _____

Work #: _____ - _____ - _____ Cell #: _____ - _____ - _____ Employer: _____

Notice of Privacy Practices: I acknowledge that Skin Speaks: Advancements in Dermatology Notice of Privacy Practices has been made available to me or is posted in a prominent location in the reception area. I know that I can ask for a copy of the notice at any time.
_____ Initials

Patient Financial Policy: I have received a copy of the SkinSpeaks: Advancements in Dermatology Patient Financial Policy.
_____ Initials

Assignment of Benefits and Related Release of Information: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or utilized by Skin Speaks: Advancements in Dermatology. I consent to the release of medical and other information related to such services for healthcare operations; and to Medicare, my insurance company, other third party payers, in order to process and pay claims, determine benefits and perform quality of care reviews. In the event that my health plan determines a service to be "not covered," I will be responsible for those charges in full.
_____ Initials

Signature of Patient or Legal Representative: _____ **Date:** _____ / _____ / _____
MM DD YYYY