Port Jefferson Dermatology

Patient Information Sheet

Welcome to our Office…

Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security#	
First Name:	**Last Name**:
Middle Initial:	**Date of Birth:** / / **Age:**
Gender: ☐ **Male** ☐ **Female**	**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other**
Street Address:	**City:**
State: **Zip:**	**Employer Name:**
Home Phone: ( )	**Emergency Contact:**
Work Phone: ( )	**Emergency Telephone#:**
Cell Phone: ( )	**Primary Care Physician:**
E-mail:	**Referring Doctor:**

Patient's Insurance Information

Primary Insurance Company Information:	**Secondary Insurance Company Information:**
PRIMARY INS. COMPANY INFORMATION	**SECONDARY INS. COMPANY INFORMATION**
Insurance's Name:_____ **Policy ID:** _____ **Group#**_____	**Insurance's Name:**_____ **Policy ID:** _____ **Group#**_____
Policy Holder Information	**Policy Holder Information**
First Name: _____ **Last Name:** _____ **Address:**_____ **City:**_____**State:**____**Zip:**_____ **Policy Holders SS#**_____ **Policy Holders Date of Birth:** _____ **Gender:** ☐ **Male** ☐ **Female** **Relationship to Policy Holder:** ☐**Self** ☐**Spouse** ☐**Child** ☐**Other**	**First Name:** _____ **Last Name:** _____ **Address:**_____ **City:**_____**State:**____**Zip:**_____ **Policy Holders SS#** _____ **Policy Holders Date of Birth:** _____ **Gender:** ☐ **Male** ☐ **Female** **Relationship to Policy Holder:** ☐**Self** ☐**Spouse** ☐**Child** ☐**Other**

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is a courtesy that the doctor accepts my insurance for payment and that if for any reason my insurance does not cover services rendered, including referrals, I am responsible for payment. All balances not paid in full within 30 days are subject to a $25 charge. After 60 days the account will be placed in collection and you will be responsible for all collection fees incurred.

By signing below, I acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy and agree to comply with all of its terms.

Today's Date:_____ Patient's Signature: _____