

WELCOME TO OUR OFFICE

DERMATOLOGY ASSOCIATES MEDICAL GROUP

Lawrence Rivkin, M.D. Steven Weiss, M.D.
 Patrice Healey, M.D. Wendy Hoffman, M.D. Joan Osder, M.D.

PLEASE PRINT AND COMPLETE ALL ENTRIES

DATE _____

MR MRS MS MD	NAME (FIRST)	(MIDDLE)	(LAST)	DATE OF BIRTH / /	AGE	MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/>	NEW UPDATE
ADDRESS (STREET)					HOME PHONE ()		
CITY		STATE		ZIP			
NAME OF EMPLOYER				OCCUPATION		WORK PHONE ()	
EMPLOYER ADDRESS (STREET)				SOCIAL SECURITY NO.		DRIVER'S LICENSE NO.	
CITY		STATE		ZIP			
SPOUSE'S NAME (FIRST-MIDDLE-LAST)			DATE OF BIRTH / /	NAME OF EMPLOYER		WORK PHONE ()	
NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU			PHONE NO ()		PHARMACY	PHONE ()	
IN CASE OF EMERGENCY CONTACT NAME			RELATIONSHIP		PHONE ()		
WHOM MAY WE THANK FOR REFERRING YOU TO US? SPECIFY NAME						PHONE ()	
<input type="checkbox"/> DOCTOR		<input type="checkbox"/> OTHER					
FAMILY PHYSICIAN			PHONE NO. ()		I WILL BE PAYING TODAY BY <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD		
COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN PATIENT							
NAME			RELATION		SOCIAL SECURITY NO.		DATE OF BIRTH
HOME PHONE ()		WORK PHONE ()		EMPLOYER			
ADDRESS			ADDRESS				
CITY		STATE		ZIP		CITY	
						STATE	
						ZIP	
<p>TO RESPECT YOUR PRIVACY PLEASE TELL US WHICH OF THE FOLLOWING NUMBERS WE SHOULD CALL TO COMMUNICATE WITH YOU REGARDING APPOINTMENT REMINDERS, LAB RESULTS, ETC. ONLY LIST THE PHONE NUMBER, OR NUMBERS, YOU WANT US TO CALL.</p> HOME: () WORK: () CELL: () OTHER: ()							
INSURANCE INFORMATION • MUST BE COMPLETED BY PATIENT							
PATIENT OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.					I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER		
SIGNED _____ DATE _____					SIGNED (INSURED OR AUTHORIZED PERSON)		
PRIMARY INSURANCE NAME AND EFFECTIVE DATE			ADDRESS (STREET)			PHONE NO.	
CITY		STATE		ZIP		GROUP NO.	
NAME OF INSURED			RELATIONSHIP	COPAY	AUTH. YES <input type="checkbox"/> NO <input type="checkbox"/>	I.D. NO.	INSURED D.O.B
SECONDARY INSURANCE NAME AND EFFECTIVE DATE			ADDRESS (STREET)			PHONE NO.	
CITY		STATE		ZIP		GROUP NO.	
NAME OF INSURED			RELATIONSHIP	COPAY	AUTH. YES <input type="checkbox"/> NO <input type="checkbox"/>	I.D. NO.	INSURED D.O.B

I understand that I am to pay co-payments at the time of service. I assume financial responsibility if I am not eligible for benefits at the time of service, if insurance determines that charges are considered cosmetic or elective, or if my deductible has not been met. I agree to pay all collection fees or attorney costs should my account be referred to a collection agency.

Patient, Parent or Guardian Signature _____

Date _____