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 ☐ M ☐	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 ☐ DOCTOR ☐ OTHER			PHONE ( )	
FAMILY PHYSICIAN	PHONE NO. ( )	I WILL BE PAYING TODAY BY ☐ CASH ☐ CHECK ☐ 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

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.

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. SIGNED _____ DATE _____	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER 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 ☐ NO ☐ / I.D. NO.	INSURED D.O.B
SECONDARY INSURANCE NAME AND EFFECTIVE DATE	ADDRESS (STREET) STATE ZIP	PHONE NO.
	CITY STATE ZIP	GROUP NO.
NAME OF INSURED	RELATIONSHIP / COPAY / AUTH. YES ☐ NO ☐ / 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** _____