

# North County Dermatology, PA

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## PATIENT INFORMATION

(please print)

Name \_\_\_\_\_  
*First M.I. Last*

SS# (opt.) \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: \_\_\_ S \_\_\_ M \_\_\_ other

Phone (\_\_\_\_\_) \_\_\_\_\_ Alt. Phone(\_\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_

Mailing Address \_\_\_\_\_  
*Street Address City State Zip*

Is this your permanent, full time address? \_\_\_\_\_ If not, please indicate home state address and phone numbers below:

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Street Address City State Zip phone*

Do you have an Email address? \_\_\_\_\_

## Please present all insurance cards and a photo ID at time of check in

Is patient the subscriber? \_\_\_\_\_ If not, please complete the following:

Insured's Name \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (if different) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

## Please read and sign below:

I hereby authorize examination and treatment, including any biopsy(ies) or procedures(s). I understand that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that a scar can result from any procedure and the type of severity of such scarring can not always be predicted before the procedure. I am also aware that North County Dermatology clinic submits specimens to an **outside laboratory** and will they will be provided my insurance information. I may receive separate billing from this laboratory for any charges not paid by my insurance company.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** Release of private health information is limited per our office "Notice of Privacy Practices" policy. A copy is available at the front desk. I authorize release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims, insurance applications and prescriptions.

**FINANCIAL RESPONSIBILITY:** I understand that it is my responsibility to know my insurance benefits and that my insurance company will be billed for covered services. I understand that I am responsible for any charges not paid by my insurance company.

***I am prepared to pay all applicable co-payments, coinsurance, deductibles, and non covered services, at the time they are rendered. (We accept cash, personal check or Care credit and a number of credit cards)***

My signature below signifies my understanding and acceptance of these policies. Guardian signature accepts personal financial responsibility for patient's charges.

Signature of patient or guardian \_\_\_\_\_ Date \_\_\_\_\_