The Belleville Dermatology Center PA

Dermatology   Cosmetic Surgery   Laser Surgery

Welcome. PLEASE PRINT: **Today's Date: _________________**

First Name ________________________________ MI ____ Last Name ______________________________________

Birth Date ______________________ Age _________ Social Security No. ________ - ______ - ________

☐MALE ☐FEMALE ☐Single ☐Married ☐Widowed ☐Divorced

Address ______________________________________ City ______________________ State ____ Zip ___________

Email ____________________________ Home Phone (____)_______________ Cell Phone (____)_______________

Employer ____ Occupation ____________________

Employer Address ____ Work Phone (____)_______________

"Meaningful Use" Statistics: Ethnicity ______ Race ______ Religion ___________ Preferred Language ______________

Person Responsible for Payment _______________________________ Relationship to Patient __________________

Address ____

Employer _________________________ Home Phone (____)_______________ Cell Phone (____)_______________

PRIMARY (Family) DOCTOR _______________________________ Referred here by ___________________________

Primary Insurance __________________________________ ID # _______________ Group # ___________________

Secondary Insurance ________________________________ ID # _______________ Group # ___________________

Subscriber Name _______________________________ Subscriber Birthdate _______________ Subscriber Social Security # ______________

PLEASE DESCRIBE YOUR SKIN PROBLEM(S) ____

____

List Any Treatments Already Tried **(including over-the-counter remedies)** __________________________________

____

List *ALL* Medications You Are Taking NOW **(including vitamins, birth control pills, etc.)**__________________________

____

List any ALLERGIES ____

Have You Ever Had… ☐High Blood Pressure ☐Diabetes ☐Liver Problem ☐Heart Problem ☐Kidney Problem

☐Bleeding Tendency ☐Surgery ☐Light Sensitivity ☐Cancer ☐Inherited Disorder

Any other significant medical problems we should know about? ____

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The Following Gives us Permission to Treat You – PLEASE READ AND SIGN

I (patient or legal guardian) authorize medical and surgical evaluation and treatment, and assume financial responsibility. I request that benefits be paid on my behalf to The Belleville Dermatology Center, PA. I understand that referral to a specialist is not a guarantee of payment, and my insurance or HMO plan may refuse to pay for my specialty care, even though it is medically necessary, and even though it has been fully authorized by my primary care physician. I understand that I am financially responsible for all co-payments and fees not covered by my insurance/HMO contract, as well as any collection expenses. I authorize the release of all medical information required for submission of insurance claims and the taking of confidential photographs as necessary.

____   ____

Signature of Patient

Signature of Legal Guardian