Atlantic Dermatology Associates, P.C.

Dermatology and Dermatological Surgery

Account Number ______________________ **Date**______________________

Patient Information ***Please Print***

Name Last______________________ **First**______________________ **Initial** __________

DOB______________________ **SSN** ______________________ **Sex** ***M*** **or** ***F***

Mailing Address Street/P O Box ______________________

City ______________________ **State** ______________ **Zip**______________

Home Phone______________ **Cell Phone**______________ **Work** ______________

Preferred Contact **PHONE** ______________________ **E-MAIL**______________________

Please circle One **CHILD SINGLE MARRIED SEPARATED DIVORCED WIDOW**

Employer/Occupation______________________ **Employer Phone** ______________________

Employer Street/P O Box ______________________

City______________________ **State**______________ **Zip**______________

Responsible Party if other than patient **Name** ______________________

Street/P O Box ______________________

City ______________________ **State**______________ **Zip**______________

Phone Number ______________________ **SSN** ______________________

HIPAA Information

Please list full name, phone number and what relation the person is to you. ***These will be the only people we will discuss your medical condition with.***

Name	Phone	Relationship
______________	______________	______________
______________	______________	______________
______________	______________	______________

Do we have permission to leave a message on your home and cell phone? Yes No

Do we have permission to leave a message with a family member? Yes NO

Emergency Contact

Name ______________________ What relation are they to you? ______________________

Phone Number(s) Home ______________ **Work** ______________ **Cell** ______________________

Primary Care Physician

Dr. Name ______________________ Address ______________________________

City __________________ State __________ Zip ______________

Phone ____________________ Fax _______________________

Referring Provider

Dr. Name ______________________ Address ______________________________

City __________________ State __________ Zip ______________

Phone ____________________ Fax _______________________

Health Insurance Information

Primary Insurance

Name of Insurance ____________________________________

Subscriber ID _________________________ **Group Number** __________________

Subscriber name _______________________ **DOB** __________ **SS#** ________________

Secondary Insurance

Name of Insurance ____________________________________

Subscriber ID _________________________ **Group Number** __________________

Subscriber name _______________________ **DOB** __________ **SS#** ________________

Preferred Pharmacy

Pharmacy Name __________________ **Address** _________________________________

City ________________________ **State** __________ **Zip** ______________________

Phone _______________________ **Fax** ___________________________________

Preferred Lab by Insurance ____

Medicare and Tricare Patients

Atlantic Dermatology Associates, P.C. are participating providers of the above insurance carriers and are authorized to receive benefits for any services furnished by out group of physicians. This includes all MEDIGAP policies to which you Medicare automatically crosses over.

Signature of Patient/Guardian ____