Atlantic Dermatology Associates, P.C.
Dermatology and Dermatologic Surgery

PATIENT DEMOGRAPHIC FORM

Patient Last Name	First	MI	Social Security No.

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Please indicate primary phone ____ Home / ____ Work / ____ Cell		Email Address

Sex M / F	Marital Status S M D W	Birthdate / /	Age	Occupation	Employer Name: Address

Guarantor Name	Birthdate / /	Social Security No.

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Relationship to Patient	Occupation	Employer

HIPAA Acknowledgements: *Please check all that apply* -

____ I acknowledge that a copy of the Notice Privacy Policy is available upon my request.
____ It is ok to leave a message regarding my health information at ___Home ___Cell ___No Messages
____ May we leave messages with family members? ___Yes / ___No
____ By default, no other persons may have access to my medical records except the following listed below:

Contact Name & Relationship	Phone

Contact Name & Relationship	Phone

Emergency Contact Name	Emergency Contact Phone	Relationship

Deemed Consent for Treatment – Release of Medical Information

Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or Hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

Financial Agreement – Insurance Agreement

I hereby authorize treatment to patient by any Atlantic Dermatology Associates provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from the insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute as covered services, including denied claims, as well as attorney fees for any related costs or collection should such action become necessary. Atlantic Dermatology Associates, P.C. are participating providers of Medicare and Tricare and are authorized to receive benefits for any services furnished by out group of physicians. This includes all MEDIGAP policies to which your Medicare automatically crosses over.

Signature of Patient/Responsible Party	Relationship to Patient	Date

Patient Name _____ Date of Birth ___ / ___ / ___

Primary Care Physician

Name:	
Address:	
Phone:	**Fax:**

Referring Physician

Name:	
Address:	
Phone:	**Fax:**

Health Insurance Information

Primary Insurance:

Name:		
Subscriber ID:	**Group Number:**	
Subscriber Name:	**DOB:**	**SS#:**

Secondary Insurance:

Name:		
Subscriber ID:	**Group Number:**	
Subscriber Name:	**DOB:**	**SS#:**

Preferred Pharmacy:

Name:	**Phone:**
Address:	

Preferred Lab by Insurance:

Name: