

GARDEN CITY DERMATOLOGY, PC
PATIENT INFORMATION

TODAY'S DATE: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Social Security #: _____ - _____ - _____

Date of Birth: ____/____/____ Age: _____ Male ___ Female ___ Marital Status: ___S ___M ___D ___W ___ Sep

Emergency Contact Name: _____ Emergency Phone: _____

Consult Requested by Dr/Pa/Nurse/Relative/Friend _____

Address: _____ Phone: _____

If not referred, how did you hear of us? _____ Yellow Pages: ___Yes Yellow Book: ___Yes

Pharmacy Name: _____ Pharmacy Phone: _____

Employer: _____ Work Phone: _____

PRIMARY INSURANCE:

Insurance Company: _____ Effective Date: _____

Policy Holder: _____ Policy Holder's SS#: _____ - _____ - _____

Policy Holder's Address: _____ Policy Holders Employer: _____

Policy Holder's DOB: _____ Relationship to Insured: _____

SECONDARY INSURANCE:

Insurance Company: _____ Effective Date: _____

Policy Holder: _____ Policy Holder's SS#: _____ - _____ - _____

Policy Holder's Address: _____ Policy Holders Employer: _____

Policy Holder's DOB: _____ Relationship to Insured: _____

AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize and direct the above named practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representative therefore to examine and make copies of all records relating to such treatment. Upon request for release of records, I hereby authorize Garden City Dermatology, PC to furnish all records and results to the parties I specify. I hereby assign, transfer and set over the above named practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical cost of care and treatment rendered to myself or my dependent in said practice. I agree to pay all monies, including the full original fees and interest, late fees, as well as additional collection fees on amounts due so that Garden City Dermatology receives full reimbursement of monies due. I understand I am responsible for any and all services not covered by my insurance company. I accept responsibility for payment of my account.

SIGNATURE: _____ DATE _____

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have had an opportunity to read and receive a
Patient Name
copy of Garden City Dermatology's Notice of Privacy Practices.

I authorize Garden City Dermatology to discuss my Protected Health Information (PHI)
(i.e. laboratory results, biopsy results) with the following family members:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient/Guardian

Date