Dermatology & Skin Surgery Center of York

PATIENT INFORMATION FORM

LAST NAME:_____ FIRST NAME:_____ MI_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____ SS#_____

DATE OF BIRTH:_____ GENDER: _____ MALE _____ FEMALE MARITAL STATUS: _____

HOME PHONE:_____ CELL:_____ WORK:_____

EMAIL ADDRESS:_____ PRIMARY LANGUAGE:_____

RACE: _____White _____African American _____Asian _____American Indian ETHNICITY: ____ Hispanic ____ Non-Hispanic

PRIMARY PHARMACY:_____ PHONE#:_____

PRIMARY/REFERRING PHYSICIAN OR PRACTICE NAME:_____

PRIMARY INSURANCE COMPANY:_____ INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ INSURED'S SS#:_____

SECONDARY INSURANCE COMPANY:_____ INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ INSURED'S SS#:_____

EMERGENCY CONTACT NAME:_____ PHONE#_____

I hereby authorize payment of medical benefits to my insurance company to be paid directly to Dermatology and Skin Surgery Center of York. I hereby agree to promptly pay for any services(s) provided to me not covered by my insurance policy. I agree to pay all copayments, coinsurance, deductibles and/or cosmetic services at the time service is rendered. If for any reason payment is not made within 90 days from the date of service, D&SSC may forward the balance due to a collection agency and I will be responsible for any collection fees associated with this service. I also agree to provide at least 24 hours' notice if I need to cancel/reschedule an appointment. Same day cancellations/ no show appointments are frowned upon and may incur a $50.00 fee that will be billed to you. We understand that emergencies occur and these situations will be taken into account on an individual basis.

Dermatology and Skin Surgery Center of York's Notice of Privacy Practices has been made available to me.

If/when any of the above information changes, I will provide the updated information promptly. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release Information at any time, by asking for and completing a new Designated Individual Release Form.

I understand that my provider and I will discuss and agree on any appropriate treatment plan, and consent to such treatment as discussed. If the patient is a minor, and present to be evaluated and/or treated by a provider at this practice without an accompanying parent/legal guardian, I will sign the appropriate Consent TO TREAT A MINOR FORM, giving permission to evaluate and treat the patient.

I have read and understand the above.

_____ DATE:_____

Signature of patient (if over 18) or patient's parent or legal guardian signature

If signed by a parent/legal guardian, print name of signature above:_____