

Today's Date: \_\_\_\_\_ **Patient Information Form** \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address-Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

Phone No(s)\*: Home: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Cell/Other: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female Marital Status:  M  S  D

Employer's Name: \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_

Primary Insurance: Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

If NOT the patient, provide Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID/SS#: \_\_\_\_\_

Insured's Employer Name (if not the patient): \_\_\_\_\_

Secondary Insurance: Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

If NOT the patient, provide Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID/SS#: \_\_\_\_\_

Insured's Employer Name (if not the patient): \_\_\_\_\_

**Emergency Contact Information / Designated Individuals Release:** D&SSC may release to, or discuss my personal health information (PHI) (except regarding treatment  payment  and/or administrative operations ) with the individuals listed below, verbally or in writing. I understand that D&SSC will make the best efforts to verify the identity of the designated parties before disclosing PHI.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph#: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph#: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

Identify any person(s) to whom PHI may NOT be provided: \_\_\_\_\_

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Dermatology & Skin Surgery Center of York. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all copayments, coinsurance, and deductibles, and for cosmetic services, at the time service is rendered. I also agree to provide at least two (2) business days notice if I need to cancel / reschedule an appointment.

Dermatology & Skin Surgery Center of York's Notice of Information 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 presents to be evaluated and/or treated by a provider at this practice without an accompanying parent/legal guardian, I hereby give my permission to evaluate and treat the patient.

I have read and understand the above.

\_\_\_\_\_  
Signature of patient (if over 18) or patient's parent or legal guardian  
If signed by a parent / legal guardian, name of legal guardian: \_\_\_\_\_

\_\_\_\_\_  
Date

\*Please inform receptionist of any phone number (s) where we may not leave a message