Raleigh Dermatology Associates, P.A.

PATIENT INFORMATION

Please fill out the following and bring to your appointment along with your insurance card and a picture I.D.

Patient's Full Name: _____ Preferred Name: _____
(First) (Middle) Last)

Address: _____

_____
(City) (State) (Zip)

Date of Birth: _____/_____/_____ Social Security # _____

Sex: ☐ Female ☐ Male Marital Status: ☐M ☐S ☐D ☐W

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race
☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Refused to Report

Ethnicity: ☐ Hispanic/Latino ☐Not Hispanic/Not Latino Language: _____

Home Phone # _____Mobile Phone # _____

Employer: _____ Work Phone # _____

Email Address: _____

Preferred Method of Communication: ☐ Postal Mail ☐ Phone ☐ Web Message

☐ **Would you like to receive email notifications of our specials or events at Skin & Cosmetic Solutions and Raleigh Dermatology?**

RESPONSIBLE PARTY INFORMATION

Name: _____Relationship: _____

Address: _____ Phone #_____

INSURANCE INFORMATION

Primary Insurance Plan Name: _____

Name of Insured (if other than patient): _____

Policy # _____Group # _____Insured Date of Birth: ____/____/____

Claims Address: _____

Secondary Insurance Plan Name: _____

Name of Insured (if other than patient): _____

Policy # _____Group # _____Insured Date of Birth: ____/____/____

Claims Address: _____

How did you hear from us?

☐ My insurance company ☐ The Yellow Pages ☐ Skin & Cosmetic Solutions
☐ Newspaper ☐ Internet/Website ☐ Seminar
☐ T.V. ☐ Saw location / Walk-In
☐ My Doctor, whose name is: _____
☐ A friend or family member, whose name is: _____
☐ Other (please specify): _____

BILLING AND INSURANCE POLICY

All professional services rendered are charged to the patient. Patient will be expected to pay for services when rendered **unless other arrangements have been made in advance.** This office does not file for outpatient services unless contracted.

INSURANCE AUTHORIZATION

I hereby authorize Raleigh Dermatology Associates, P.A. to furnish information to insurance carriers concerning all illness and treatments. I hereby assign to the physician all payments for medical services rendered to myself if assignment is accepted by said physician in the event insurance is filed for me or my dependents. **I understand that I am responsible for any amount not covered by insurance**. A copy of this signature is as valid as original.

All forms will be signed electronically on the day of your appointment.