Dermatology Associates, Ltd

18425 West Creek Dr. Tinley Park, IL 60477 | 13401 S. Ridgeland Ave. Palos Heights, IL 60463

Patient name:			**Age:**	
Date of Birth:	«Person_Birth_Date»	**Sex: M F**	**SS# :**	
EMAIL ADDRESS:			**Marital status: S M W D**	
Address:				

Home Phone:		**Cell Phone:**		**Work phone:**	

Employer:		**Address:**			
City:		**State:**		**Zip:**	

Responsible party (if other than patient):	

Emergency contact (phone# other than your home)	**Name:**	
Phone#:	**Relationship:**	

Ethnicity:	□ **Hispanic** □ **non-Hispanic**	**Primary language:**	
Race:	□ **African American** □ **Asian** □ **American Indian Native Alaskan** □ **Native Hawaiian or Pacific Islander** □ **White**		

Permission to either leave detailed medical information (biopsy results, prescription information, medical instructions) on your home or cellphone voice-mailbox ? ***Or with another person? ___________________________ ph#_______________***		***YES***	***No***
Preferred method of contact:	***home phone voice mail***	***cell phone text***	***email***

How did you hear about our practice?	☐ **another MD**	☐ **friend**	☐ **phone book**
	☐ **mailing**	☐ **other (specify)** _________________	
Primary care physician:			

Please present your insurance card and, if applicable, your referral to front desk person

Primary insurance:	«Person_Primary_Insurance»	**HMO?**	□ **yes** □ **no**
ID#	«Person_Primary_Ins_ID»	**Group #:**	«Person_Primary_Ins_Group_Number»
Ins Phone #:			
Policy Holder Name:		**Address:** ____________________ **City & State**___________	**Relationship to patient:** ______________________
DOB:	«Person_Primary_BirthDate»	**SS#:**	

Please present your insurance card and, if applicable, your referral to front desk person

Secondary insurance:	«Person_Secondary_Insurance»	**HMO?**	□ **yes** □ **no**
ID#		**Group #:**	
Ins Phone #:			
Policy Holder Name:		**Address**___________________ **City & State** ________________	**Relationship to patient**
DOB:		**SS#:**	

PLEASE READ BELOW AND SIGN AT EACH "X"

I authorize the release of medical information to my primary care physician, consultants (if needed), and as necessary, for the processing of insurance claims, applications, and prescriptions. I also authorize payment of medical benefits to the physicians of this office.

Patient or Responsible party : X___________________________________date__________________

I have read the information provided by this office staff regarding NOTICE OF PRIVACY PRACTICES (HIPAA)

Patient or Responsible party: X___________________________________date_________________

I have read this document and I certify this information to be true and correct and have responded as required.
I understand and agree that regardless of my insurance status, I am ultimately responsible for all charges incurred for any and all services rendered by this practice. I agree to notify this office immediately of any information changes that might affect billing, insurance claims or mail delivery. I also acknowledge that in the event of a NSF check, a $35 fee will be added to the balance of my account. ***I acknowledge that this document also serves to inform me of a required 24 hour notice of cancellations or my account may be charged for an office visit and that if I cancel or fail to show up for two or more appointments, I will be required to prepay for any further scheduled appointments.***

Patient or Responsible Party Signature: X____date ____________