WINSTON SALEM DERMATOLOGY & SURGERY CENTER, PLLC

Patient Information as of _____ (enter today's date)

PATIENT Name as it appears on insurance card:

_____ □ Jr □ Sr
First Middle Last

SS#: _____ Date of Birth: ____/____/____ Age: _____ Sex: □ Male □ Female

Status: □ Single □ Married □ Divorced □ Widow/Widower Student ?: □ F/T □ P/T

Address: _____
Street # Street Name Apt. #

_____
City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____ May we call you at work? _____

Cell Phone: (_____) _____ Email: _____

If Minor, seen with parent or legal guardian? □ Yes □ No
If Minor, Parent Name or: _____ Date of Birth ____/____/____
Legal Guardian First Middle Last

Please note that minors under 18 years of age unaccompanied by a parent or legal guardian will not be seen on their initial visit. Follow-up visits of minors unaccompanied by a parent or legal guardian require a pre-authorized consent to treat the patient. More information can be obtained from the receptionist.

Employer: _____
Name Address Phone #

Insurance Information: Do you have insurance? □ Yes □ No **Please present insurance cards and photo ID to the receptionist**

Primary Insurance Carrier: _____ Relationship to Insured: _____

Name of Insured: _____ Insured Date of Birth: ____/____/____ Insured SS#: _____

Secondary Insurance Carrier: _____ Relationship to Insured: _____

Name of Insured: _____ Insured Date of Birth: ____/____/____ Insured SS#: _____

In Cases of Emergency, whom should we notify? _____ _____
Name and Relationship Phone

Primary Care Physician: _____ Referred to our office by: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, MASTERCARD, VISA AND DISCOVER. Your signature below indicates that you understand and accept this policy. Further, your signature authorized the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed. Your signature below also indicates your consent for treatment by the Doctor and/or authorized medical personnel. **Please Check Relationship: □ Parent/Guardian □ Healthcare POA □ Other**

_____ _____
Print Name Signature Date

Pharmacy Preference: _____ Pharmacy Phone #: _____

Pharmacy Street/City: _____

Yes, I defer to receive a copy of the HIPAA policy for Winston Salem Dermatology & Surgery Center _____ (please initial)