GREATER WASHINGTON DERMATOLOGY, PA/ CAPITAL DERMATOLOGY, PA
NEW PATIENT/PATIENT UPDATE INFORMATION SHEET

NAME: _____ Date of Birth _____ **email**:_____

Age: _____ Sex: M F Marital Status: S M W D Sep Spouse: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell:_____ Work: _____

Employer: _____Relationship to Subscriber: _____

Please answer the questions below by Government mandate:

Race: Caucasian American Indian or Alaska Native Asian African American Native Hawaiian or other Pacific Islander Other Refuse to answer

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Refuse to specify

Preferred Language_____

Referred by: _____Family Physician: _____Phone:_____

Emergency Contact (other than spouse): _____ Phone: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND PHOTO-ID TO THE RECEPTIONIST AT EACH VISIT.

INSURANCE COVERAGE:

Insurance company:_____Pol#_____Grp#_____

Subscriber:_____DOB:_____Phone#_____

You have the right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, and any other person identified by you.

With whom may we share your medical information?_____

May we leave medical information on your answering machine? Circle one: YES NO

Pharmacy Name:	**Address and phone number:**

We will bill your insurance company if we participate with that company. You are responsible for any & all charges that your insurance company does not cover such as deductibles, co-pays, and non-covered services, which are payable at the time of service. Parents are responsible for payments on child accounts. All tissue removed will be sent for pathologic examination. There is a $35 fee for returned checks. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company and to the billing service to receive payment. *HMO participants:* In order for your insurance to pay for your visit, it is *your* responsibility to obtain referrals from your primary care physician for ***each visit***. I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. My requested restrictions of use of this information are notated above. I certify that I understand the above and that the information I have given is correct to the best of my knowledge:

_____ _____

Signature (parent/guardian if minor) Date