DEL MAR DERMATOLOGY

Today's Date	*Are you a new Patient?* YES NO	*Who were you referred by?*

PATIENT INFORMATION

PATIENT'S NAME (LAST NAME, FIRST NAME, M.I.)		*IF PATIENT IS A MINOR, PLEAS E WRITE RESPONSIBLE PARTY NAME HERE:*	
BILLING ADDRESS	*CITY*	*STATE*	*ZIP WITH POSTAL CODE*
PERMANENT ADDRESS (if different)	*CITY*	*STATE*	*ZIP WITH POSTAL CODE*
HOME PHONE ( ) -	*WORK PHONE* ( ) -	*CELL PHONE* ( ) -	
SEX *MALE* *FEMALE*	*BIRTHDAY*	*EMAIL ADDRESS:*	

PATIENTS OR RESPONSIBLE PARTY MARITAL STATUS

☐ *SINGLE* ☐ *MARRIED* ☐ *DIVORCED* ☐ *STUDENT* ☐ *WIDOWED* ☐ *REGISTERED DOMESTIC PARTNER*

PATIENTS OCCUPATION AND EMPLOYER:

ETHNIC GROUP/RACE: *PREFERRED LANGUAGE:*

DO YOU WANT YOUR RECORDS SENT TO A PHYSICIAN ? IF SO PLEASE PROVIDE NAME, PHONE # OR ADDRESS:

CASH PAY ? YES NO

INSURANCE INFORMATION (PLEASE PROVIDE ALL I.D. CARDS)

WHO IS THE MAIN INSURANCE POLICY HOLDER?

SELF ☐ *PARENT* ☐ *SPOUSE* ☐ *OTHER*

PLEASE FILL IN THE MAIN POLICY HOLDERS INFORMATION BELOW

PRIMARY INSURANCE COMPANY		*SECONDARY INSURANCE COMPANY*	
SUBSCRIBER NAME	*DATE OF BIRTH*	*SUBSCRIBER NAME*	*DATE OF BIRTH*

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON		*RELATIONSHIP TO PATIENT*
HOME PHONE ( ) -	*WORK PHONE* ( ) -	*CELL PHONE* ( ) -

PHARMACY INFORMATION

PHARMACY NAME: *FULL ADDRESS OR STREET NAME*	*PHARMACY PHONE OR ZIP CODE*

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS AND CERTIFICATION OF ACCURATE INFORMATION

I HEARBY AUTHORIZE DR. AGATA MARRIOTT TO RELEASE INFORMATION WHICH IS NORMALLY REQUIRED IN THE COURSE OF MY TREATMENT FOR THE SOLE PURPOSE OF PROCESSING ANY INSURANCE CLAIM(S) SUBMITTED.

I HEARBY AUTHORIZE MY INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO DR. AGATA MARRIOTT FOR ANY INSURANCE BENEFITS FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNMET DEDUCTIBLE, CO-PAYS AND FOR ANY CHARGES OF SERVICES NOT COVERED BY MY INSURANCE, UNLESS SPECIFICALLY PROHIBITED BY MY INSURANCE PLAN.

I HAVE REVIEWED THE PRECEEDING INFORMATION AND I CERTIFY THAT THIS INFORMATION IS CORRECT. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FINANCIAL LOSS DUE TO INACCURATE OR INCOMPLETE INFORMATION PROVIDED BY ME.

CANCELLATION FEE $25.00 THIS IS OUR NEW POLICY REGARDING NO SHOWS AND NO CALL WITHIN 24 HOURS OF THE APPOINTMENT TIME. REMINDER CALLS ARE A COURTESY.

PRINTED NAME:**____**

SIGNED:**____** ***DATE:*****__________________**

(PATIENT OR RESPONSIBLE PARTY, IF PATIENT IS A MINOR)

Due to HIPAA laws (Health Insurance Portability and Accountability Act of 1996) we ask that our patients sign this form allowing us permission to leave messages regarding your personal health, treatment, or payment for treatment. This request is for communication channels only and will be used solely for that purpose.

Please complete all that apply. Where you list more than one communication option, please circle the preferred method.

	Ok to leave message (circle)
I want Del Mar Dermatology to contact me by telephone at ( )__________________	yes no
I want Del Mar Dermatology to contact me by cell phone at ( )_________________	yes no
It is okay to contact me at work at ( )____________________	yes no

Please list family members we may leave messages with:____

Del Mar Dermatology may NOT leave messages with any family members ___________

Signature______________________________________ Date______________________________________