DERMATOLOGY & COSMETIC SURGERY CENTER, PC

100 North Wren Drive ● Pittsburgh, PA 15243 ● Phone (412) 429-2570 ● Fax (412) 429-2572

PATIENT INFORMATION:

Patient Name: _____ Jr. ☐ Sr. ☐
(Same as insurance card) *First* *Middle* *Last*

Preferred Name: _____ Gender: _____
(if different than legal name)

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

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widow/Widower ☐ Domestic Partnership

Race/Ethnicity: _____

Address: _____
Street # Street Name Apt/Suite#

_____
City State Zip

Primary Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____
May we leave personal medical information on your identifiable primary or cell #? ☐ **YES** ☐ **NO**

Email (for patient portal access): _____ Occupation:_____

Preferred method of contact for appointment reminders: ☐ **Voice** ☐ **Email** ☐ **Text**

FAMILY PHYSICIAN/OTHER IMPORTANT INFORMATION:

Family Physician: _____ Telephone#: (_____) _____-_____

Do you give our office permission to discuss your medical information with any family members or other caregivers? ☐ **YES, If yes, please complete the below information.** ☐ **NO**

Name: _____Relationship: _____

Phone#: (_____)_____-_____

Name: _____Relationship: _____

Phone#: (_____)_____-_____

Emergency Contact: _____Relationship to Patient:_____
Phone: (_____)_____-_____

RECEIPT OF NOTICE OF PRIVATE PRACTICES:
My Signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices (Available on Request):

Patient or Responsible Party Signature: _____ **Date**:___/_____/_____

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INSURANCE AND FINANCIAL

YOU DO NOT NEED YOUR INSURANCE CARD TO COMPLETE THIS SECTION.

Insurance Information: Do you have health insurance? ☐ Yes ☐ No (If Yes, please complete below)

Primary Insurance Carrier: _____

Name of Insured (Policy Holder): _____ Policy Holders Date of Birth: _____/___/_____

Address of Policy Holder:

☐ Same as patient

☐ Other, please complete here _____

Street # Name City State Zip

Secondary Insurance Carrier: _____

Name if Insured (Policy Holder): _____ Policy Holders Date of Birth: ____/_____/_____

Do you have an insurance deductible? ☐ **Yes** ☐ **No**

Is your insurance through a hospital group policy? ☐ **Yes** ☐ **No**

(Meaning does the Policy Holder work for a hospital, affiliate, or university?)

Are you required to use a Home Host Facility for services? ☐ **Yes** ☐ **No**

RELEASE OF INFORMATION/AUTHORIZATION ON FILE

I verify the accuracy of this information and I authorize the release of medical information necessary to process any claims. I request payment of my claims and, if the payer accepts assignment, authorize payment directly to the physician or supplier for the services described.

Patient or Responsible Party Signature: _____ **Date**: ____/_____/_____