

Today's Date: _____

Patient name: _____ Date of Birth: _____
(last) (first) (m.i.)

Prefer to be called: _____ S. S. #: _____ Sex: M/F

Address: _____
Street City State Zip code

Home phone: _____ Work phone: _____

Employer: _____ Occupation: _____

If student: Full time Part time Name of School _____

Primary (referring) physician (Full Name): _____ M.D.
First Last

Additional physician you wish to receive correspondence: _____ M.D.
First Last

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Date of Birth: _____ Sex: M/F
(last) (first) (m.i.)

Address: _____
Street City State Zip code

S. S. #: _____ Home phone: _____ Relationship to Patient: _____

Employer: _____ Employer Address: _____

Work phone: _____

INSURANCE INFORMATION

Primary

Secondary

- Blue Choice
- Preferred Care
- Monroe Plan/BC Option
- Medicare
- Aetna
- United Health Care
- BC/BS PPO
- BC/BS of Rochester
- Sidney Hillman
- Workman's Compensation
- FLHP
- ViaHealth
- Child/Family Health Care Plus
- Other

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- Other

Name of Insured: _____
Policy #: _____
Insured Date of Birth: _____

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Do we have your permission to: *(Please circle Yes or No)*
Leave a message on your answering machine at home? Yes or No
Leave a message at your place of employment? Yes or No
Discuss your medical condition with any member of your household? Yes or No
If yes, whom? _____ Relationship? _____

AUTHORIZATION FORM (For Medicare)

Name of Beneficiary _____ Health Insurance Claim Number _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Partners of Western New York, LLP for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature Date

Please present insurance cards to the receptionist at the time of visit so copies may be made.