



triad dermatology

# New Patient Information Sheet

## WELCOME TO OUR PRACTICE!

Please help us serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION						
ACCOUNT #	SOCIAL SECURITY NUMBER	TITLE	LAST NAME	FIRST NAME	MI	
STREET ADDRESS (ROAD OR STREET)			APARTMENT OR SECOND ADDRESS LINE			
ZIP CODE	CITY		STATE			
MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)			APARTMENT OR SECOND MAILING ADDRESS LINE			
ZIP CODE	CITY		STATE			
HOME PHONE	D.O.B. (MM/DD/YY)	SEX (M/F)	RACE			
MARITAL <input type="checkbox"/> S-Single <input type="checkbox"/> D-Divorced <input type="checkbox"/> X-Separated	<input type="checkbox"/> M-Married <input type="checkbox"/> W-Widow	EMPLOYMENT <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None	<input type="checkbox"/> R-Retired <input type="checkbox"/> N-None	STUDENT T <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None	REL. TO INSURED <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> CH-Child	<input type="checkbox"/> O-Other
EMPLOYER INFORMATION (ADULT)						
PATIENT'S EMPLOYER			SPOUSE'S NAME			
WORK PHONE			EMPLOYER			
ADDRESS			SOC. SEC.#	D.O.B.		
FOR CHILDREN ONLY						
FATHER'S FULL NAME			MOTHER'S FULL NAME			
HOME PHONE ( ) ( ) ( )	WORK PHONE ( ) ( ) ( )	HOME PHONE ( ) ( ) ( )		WORK PHONE ( ) ( ) ( )		
EMPLOYER			EMPLOYER			
EMPLOYER'S FULL ADDRESS			EMPLOYER'S FULL ADDRESS			
FATHER'S DATE OF BIRTH	FATHER'S SOC. SEC.#	MOTHER'S DATE OF BIRTH		MOTHER'S SOC. SEC.#		
PLEASE COMPLETE THE FOLLOWING RELATING TO THE PATIENT:						
PRIMARY INSURANCE	_____ (NAME)		_____ (ADDRESS)			
SECONDARY INSURANCE	_____ (NAME)		_____ (ADDRESS)			
REFERRING PHYSICIAN	_____ (NAME)		_____ (ADDRESS)			
FAMILY PHYSICIAN	_____ (NAME)		_____ (ADDRESS)			

### POLICY STATEMENT ON FEES AND COLLECTION:

It is the policy of Triad Dermatology, P.A. that payment is due at the time services are rendered with the exception of HMO s, PPO s, Medicare and Medicaid. Co-pays are due at the time of service.

### POLICY STATEMENT ON HEALTH INSURANCE:

I understand that health insurance is an agreement between my insurance company and me to pay a specified amount for medical care. My doctor's fees are not based on the amount insurance will pay. The amount approved by my insurance company for payment on a particular procedure may be more or less than the fee charged. I understand that full payment for my treatment remains my exclusive financial responsibility, except for HMO s, PPO s, Medicare and Medicaid. I further agree that NON-COVERED SERVICES as determined by my insurance company will be my sole financial responsibility and are to be paid at the time of services or within thirty (30) days upon receipt of my Explanation of Benefits.

I authorize the release of medical information to my primary care or referring physician, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Triad Dermatology, P.A.

Signature of Patient or Responsible Party (Minor Child) \_\_\_\_\_

Date \_\_\_\_\_