

DERMATOLOGY ASSOCIATES

220 Southbrooke Drive
Waterloo, Iowa 50702

319-236-3444
800-245-6246
Fax 319-236-0257

PATIENT INFORMATION

DATE _____

NAME _____

LAST

FIRST

MIDDLE

ADDRESS _____

#

STREET

TELEPHONE _____

CELL PHONE _____

HOW DID YOU HEAR OF

OUR OFFICE? _____

CITY

STATE

ZIP

DATE OF BIRTH _____ AGE _____ SEX M F MARITAL STATUS S M W D SEP

SOCIAL SECURITY _____ SPOUSE _____

CHILDREN _____

(LIVING AT HOME)

EMPLOYER _____ EMPLOYER PHONE NUMBER _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN A PATIENT HERE BEFORE? YES NO _____

(Relationship - Name)

IN CASE OF EMERGENCY - CONTACT _____ HOME # _____

IF 18 OR UNDER _____

FATHER

MOTHER

GUARDIAN

PARENT OR RESPONSIBLE PARTY (if different from patient)

NAME _____

LAST

FIRST

MIDDLE

RELATIONSHIP

ADDRESS _____

CITY

STATE

ZIP

HOME PHONE _____ WORK PHONE _____ SS# _____

DATE OF BIRTH ___/___/___ SEX: M F EMPLOYER _____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

I hereby give permission to Dermatology Associates to provide necessary treatment and submit charges for any services rendered to my insurance carrier(s)/Medicare. I also understand that I am financially responsible for any charges not covered by this policy. I authorize the release of any information necessary to determine these benefits, along with the payment of benefits directly to Dermatology Associates. I also authorize the release of medical information for continuing health care services to or from my referring or consulting physicians.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

*** PLEASE SEE REVERSE SIDE FOR INSURANCE INFORMATION***

INSURANCE INFORMATION (Please present insurance card(s) to our receptionist.)

Primary Company Name _____

Secondary Company Name _____

Ins. Address _____

Ins. Address _____

Name of Insured _____

Name of Insured _____

Date of Birth _____

Date of Birth _____

Insured's ID# _____

Insured's ID# _____

Group # _____

Group # _____

Effective Date _____ Cancelled _____

Effective Date _____ Cancelled _____

Employer Name _____

Employer Name _____

Relationship of patient to the Insured _____

Relationship of patient to the Insured _____