

# Dermatology Treatment & Research Center, PA

## Patient Information

New Patient

Established Patient

Dr. Abramovits

Dr. Brown

Dr. Kodama

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### Patient Information

**PLEASE PRINT LEGIBLY**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_ DOB: \_\_/\_\_/\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_

Hm Ph: \_\_\_\_\_ Cell: \_\_\_\_\_ Cell Carrier \_\_\_\_\_ Wk: \_\_\_\_\_

Pt's SS# \_\_\_\_\_ Sex: **M F** Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Mar Status: **M S D W** E-mail address: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

**What number may we leave detailed messages** (reappointment confirmation, return call needed, etc):

**Hm Cell Work Other:** \_\_\_\_\_

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### Insurance Policy Holder Information

**Relation to Patient**  Self  Spouse  Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_ DOB: \_\_/\_\_/\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_

Hm Ph: \_\_\_\_\_ Cell: \_\_\_\_\_ Wk: \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Sex: **M F** Mar Status: **M S D W** E-mail address: \_\_\_\_\_

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### Insurance Information

#### Primary Insurance

Insurance Co/Network: \_\_\_\_\_

#### Secondary Insurance

Insurance Co/Network: \_\_\_\_\_

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### Referring Physician's Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize the release of any medical information required by my insurance carrier for services rendered to me in order to process claims on my behalf. I request that payments of authorized medical benefits be made to the above provider. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I understand and agree that if I cannot be reached by phone or mail, my emergency contact may be called. I further understand that failure to cancel future appointments will result in a \$25 fee.

**Patient/Guardian's Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_