PATIENT INFORMATION SHEET **(PLEASE PRINT - Fill out completely and return to receptionist)** *8-2014*

Patient's Personal Information: **Today's Date:** _____ /_____ / _____

Name:_____ **Date of Birth** _____/_____/_____
Last First Middle Initial

Address_____ **Age:** _____ **Gender:** ___ Male ___ Female

City _____ **State** _____ **Zip** _____ **Marital Status:** ___ Single ___ Divorced ___ Married ___ Widowed

Home phone _____**Cell phone**_____ **Social Security #** _____

Work phone _____**other:** _____

Employer: _____ **Employed:** Full time Part time Retired

Occupation: _____ **Student:** Full time Part time

Address _____ **Nearest relative not residing with you**:

City _____ **State** _____ **Zip** _____ Name:_____ Phone # _____

Race: _____ **Ethnicity** _____ **Favorite Pharmacy:** _____

Referred By: _____ City _____ Phone # _____
Family Physician: _____ City _____ Phone # _____

For Dependents Only - Parent Information:

FATHER_____ **Address** _____ **Home # _____ Work # _____Other # _____ Date of Birth _____**

Employer _____ **SS# or Drivers License #**_____

MOTHER_____ **Address** _____

Home # _____ Work # _____ Other # _____ Date of Birth _____

Employer _____ **SS# or Drivers License #**_____

Payment Information:

Primary Insurance name _____ **Secondary Insurance name** _____

Name of insured _____ **Name of insured** _____

Insured's Date of Birth _____ **Insured's Date of Birth** _____

Insured's ID # & Group #_____ **Insured's ID # & Group #** _____

Please provide receptionist with your current insurance card(s) and photo ID.

Patient relationship to insured: SELF SPOUSE CHILD **Patient relationship to insured**: SELF SPOUSE CHILD

☐ **I do not have insurance, but this is how I will pay in full for the visit today**: CASH CHECK CREDIT/DEBIT

Person Financially Responsible _____ **SS# or DL#** _____ **Date of Birth**___/____/___

Address _____ City _____ State _____ Zip _____

Home # _____ Other # _____ Employer _____ Work #_____

Patient Relationship to responsible party: SELF SPOUSE CHILD **** Photo ID REQUIRED ****

I understand that co-pays and/or deductibles are due at the time of service. There will be a $35 charge for returned checks. I have read the current GDMD collection procedures at reception counter and agree to the terms. Authorization to release information: Protected health information may be disclosed or used for treatment, payment, or health care operations (TPO) including processing insurance and with other physician(s) involved in my care. I have had the opportunity to review the "Notice of Privacy Practices" and may obtain a copy if I desire. I authorize my insurance company to pay Greater Des Moines Dermatology, P.C. directly for all surgical and/or medical benefits. I am financially responsible for ALL non-covered services. Medicare authorization: I understand this is a lifetime authorization. I authorize access to surescripts database to provide prior medication history. Interest is charged on delinquent accounts. You will be provided access to the patient via the email you provide.

Patient (Parent if Minor) Signature _____Printed Name _____ Date ____/____/_____