NEW PATIENT INFORMATION

Name ____

Last Name First Name Middle Initial

Permanent Address____

City ________________________________ State ______________ Zip Code ____________________

Daytime Phone #________________Cell Phone # ________________Home Phone # ___________________

Email Address: ___________________________ Preferred Language: _____________________________

Date of Birth _____________ Sex: ___M ___F SS# ___________________________

Please check your Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino ☐ Unknown or Not Reported

Please check your Race: ☐ White ☐ Black or African American ☐ Asian ☐American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ More than one Race ☐ Other Race ☐ Unknown or Not Reported

Who may we thank for referring you? ____

Do you want a letter sent to your referring doctor? ___Yes ___No Doctor Name _______________________

In case of emergency who should be notified ______________________________Phone ________________

Are there other members of your household that are patients with Southern Illinois Dermatology? Yes or No

RESPONSIBLE PARTY INFORMATION

Please complete this section if someone other than the patient is responsible for the payment of services.

Name ____ Relationship to Patient ____________________

Address _______________________Phone_________________Resp. Party's Date of Birth____________

City ________________________________ State _____________ Zip Code______________________

PRIMARY INSURANCE

If you have provided us a copy of your insurance card, please complete the Insured's DOB and Insurance Company Name fields only. If you have not provided us with a copy of your insurance card, please complete all fields.

Policy # ____Group # ________________________________

Insured's Name _______________________________ Relationship to Patient ________________________

Insured's Social Security # or ID# __________________________Insured's DOB_____________________

Insurance Company Name ____

SECONDARY INSURANCE

If you have provided us a copy of your insurance card, please complete the Insured's DOB and Insurance Company Name fields only. If you have not provided us with a copy of your insurance card, please complete all fields.

Policy # ____Group # ________________________________

Insured's Name ________________________Relationship to Patient _______________________________

Insured's Social Security # or ID# __________________________ Insured's DOB_____________________

Insurance Company Name ____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize the release of any information relating to all claims for benefits submitted on my behalf. I also authorize the payment of medical benefits directly to the physician.

____ ______________________ ________________

Responsible Party Signature Relationship Date