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 select your Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino ☐ Unknown or Not Reported

Please select 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 primary 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/provider.

_____ _____ _____
Responsible Party Signature Relationship Date