NEW PATIENT INFORMATION

Name _____DOB: _____ Sex: ☐ M ☐ F
Last Name First Name Middle Initial

Address_____ City _____ State _____ Zip _____

Cell Phone # _____Home Phone # _____ Daytime Phone #_____

Alternate Phone #_____ Indicate Preferred Phone (Check One): ☐ Cell ☐ Home ☐ Daytime ☐ Alternate

Email Address: _____

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

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

Preferred Language: _____

Who may we thank for referring you? _____

Do you want a letter sent to your primary doctor? ___Yes ___No Doctor Name _____

Emergency/Alternate Contact Name_____ Relationship _____Phone _____

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

BILLING AND INSURANCE INFORMATION

Responsible Party (if other than patient)

Name _____ Relationship_____ Phone _____DOB_____

Address _____City _____ State _____ Zip _____

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 for both primary and any secondary insurance.

Policy # _____Group # _____ Insured's ID# _____

Insured's Name _____ Relationship to Patient _____ Insured's DOB_____

Insurance Company Name _____

Secondary Insurance

Policy # _____Group # _____ Insured's ID# _____

Insured's Name _____ Relationship to Patient _____ Insured's DOB_____

Insurance Company Name _____

ASSIGNMENT, RELEASE AND CONSENT

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. I have had an opportunity to review the practice's Financial Policies and Notice of Privacy Practices. I understand that I also may request of copy of either of these notices. By providing my cell number and/or email address to Southern Illinois Dermatology, I authorize communication by these means. I acknowledge that standard text messaging and email are unencrypted and carry a risk of unauthorized interception. I accept this risk and understand I can opt out of these electronic communications at any time.

_____ _____ _____
Patient or Responsible Party Signature Relationship Date