

**GREATER WASHINGTON DERMATOLOGY, P.A./CAPITAL DERMATOLOGY, PA
NEW PATIENT/PATIENT UPDATE INFORMATION SHEET**

NAME: _____	Date of Birth _____	SS# _____
Age: _____	Sex: M F	Marital Status: S M W D Sep
Spouse's name: _____		
Address: _____	Apartment #: _____	
City: _____	State: _____	Zip: _____
Phone: Home: _____	Work _____	Cell _____
Email _____		
Employer: _____	Relationship to Subscriber: _____	

Referred by: _____	Family Physician: _____	Phone: _____
Emergency Contact (other than spouse): _____	Phone: _____	

PRIMARY COVERAGE		
INSURANCE COMPANY: _____	Pol #: _____	Grp#: _____
Subscriber: _____	DOB: _____	Soc. Sec # _____
Phone# _____		
SECONDARY: Please note: We file secondary insurance only for Medicare patients whose secondary participates in Medigap.		
INSURANCE COMPANY: _____	Pol #: _____	Grp#: _____
Subscriber: _____	DOB: _____	Soc. Sec # _____
Phone# _____		

COMMUNICATION OF CONFIDENTIAL PERSONAL HEALTH INFORMATION:
As a matter of medical confidentiality, we do not share your personal health information with those who are not authorized to see it. We do share it with your other physicians, your insurer, and with mandated governmental agencies (ie: tumor registries). A copy of our full policy is posted in each office. You may request a copy of it.
May we leave answering machine or voice mail messages on the above phone numbers? Y N
With whom may we share your personal health information (ie: spouse, etc) _____

List any restrictions here: _____

We will bill your insurance company if we participate with that company. I am responsible for any & all charges that my insurance company does not cover such as deductibles, co-pays, and non-covered services, which are payable at the time of service. Parents are responsible for payments on child accounts. All tissue removed will be sent for pathologic examination at additional cost. There is a \$35 fee for returned checks. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company and to the billing service to receive payment. ***HMO participants:*** In order for my insurance to pay for your visit, it is *my* responsibility to obtain referrals from my primary care physician for ***each visit***. I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. My requested restrictions of use of this information are notated above. I certify that I understand the above and that the information I have given is correct to the best of my knowledge:

Signature (parent/guardian if minor) _____
Date 04-05v1