TRIBECA PARK DERMATOLOGY

PATIENT INFORMATION SHEET

Patient Name:____

Street Address:____

City:____________________ State:________________ Zip Code:____________

Telephone: (Home)____________________ (Work)______________________

Cell Phone:______________________ Email address:______________________

Sex: ☐ Male ☐ Female Date of Birth:__________ Last 4 Digits of SS.#:__________

Relationship status: ☐ Single ☐ Married ☐ Partnered Name of Spouse/Partner :____________

Emergency Contact:__________________ Relationship:______________________

Phone (h):______________ (w):________________ (cell):________________

Name of employer:____

Work Address:____

Who referred you?____

What is the name of your primary care physician?______________________________

What is the name of your Insurance Carrier? ______________________________

Name of the primary policy holder (if other than self)?________________ DOB?________

Pharmacy:____________________ Address/Tel:__________________________

I understand that all medical costs incurred by me are my responsibility, including any charges my insurance fails to pay. I also understand thatI am responsible for any collection and/or legal efforts that may be necessary on my account.

Signature of Patient:______________________________ Date:____________

I authorize payment of medical benefits to the physician for services provided.

Signature of Insured:______________________________Date:__________________