Dermatology Associates, P.C.

16 Chestnut Street	95 Chapel Street	128 Carnegie Row	440 E. Central Street
Foxboro, MA 02035	Norwood, MA 02062	Norwood, MA 02062	Franklin, MA 02038

781-762-5858

Patient Information

Last Name:_________________________ **First Name:**_____________________________ **MI:**_______

Home Address:___________________________**City:**_____________**State:**____________**Zip:**________

Primary Phone:_______________**Secondary Phone:**______________ **Work Phone:**_________________

Date of Birth: _________________ **Sex:** ☐ M ☐ F

☐ I understand Dermatology Associates, P.C. uses a computer generated autodialing system to confirm my appointments and by checking this box I express consent to autodial my cell phone number.

Social Security Number:____________________

Employer:_______________________________

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other

Primary Care Physician:____________________

Referring Provider: ____________________________

Primary Language: _________________________

Personal Email Address:_______________________

Please do not sign me up for the Patient Portal ☐

Please do not send me emails about skin care tips, services, and specials ☐

Race: *Please select one*

- ☐ American Indian or Alaska Native
- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian
- ☐ Other Race: ___________________
- ☐ Refuse to Report

Ethnicity: *Please select one*

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Refuse to Report

Insurance Information

Insurance Name:___________________________

Subscriber Number:________________________

Group Number: ___________________________

Insurance Address:_________________________

Subscriber's Name:_________________________

Subscriber's DOB: _________________________

Subscriber's SS#:______-________-___________

Secondary Information

Insurance Name:___________________________

Subscriber Number:________________________

Group Number: ___________________________

Insurance Address:_________________________

Subscriber's Name:_________________________

Subscriber's DOB: _________________________

Subscriber's SS#:______-________-___________

Medical Information

Allergies: ____

Pharmacy:________________________________ **Address:**_______________________________________

Emergency Contact:_____________________ **Relationship:**_____________ **Phone:**_________________

Authorization and HIPAA

I hereby authorize the release of medical information necessary to process my insurance claim and I assign benefits directly to Dermatology Associates, PC. I understand that I am responsible for any balance and copay as per my insurance company contract.

Notice of Privacy Practices Acknowledgement and Consent: By signing below, I acknowledge that I have been provided a copy of the Dermatology Associates, P.C. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of the Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff and its business associates.

____

Signature (Patient or Parent of a Minor) Date