Dermatology Associates, P.C.

16 Chestnut Street Foxboro, MA 02035

95 Chapel Street Norwood, MA 02062

128 Carnegie Row Norwood, MA 02062 440 E. Central Street Franklin, MA 02038

781-762-5858

| | <u>Patient Ir</u> | <u>nformation</u> | |
|--|--|--|---------------------------|
| Last Name: | First Na | me: | MI: |
| Home Address: | Cit | <u>y:State:</u> | Zip: |
| Primary Phone: | Secondary Phone | : Work Ph | one: |
| 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 | |
| Social Security Number: | autodianing system to commit my ap | | |
| Employer: | | Marital Status: □ S □ M □ | D D W Other |
| Primary Care Physician: | | Referring Provider: | |
| Primary Language: | | Personal Email Address: | |
| Race: Please select one | | Please do not sign me up for the Patient Portal \square Please do not send me emails about skin care tips, services, and specials \square | |
| ☐ American Indian or ☐ Black or African Ar ☐ Other Race: | nerican | | ☐ Asian ☐ Native Hawaiian |
| Ethnicity: Please select one | | | |
| Hispanic | Non-Hispar | ic Refuse to Re | port |
| Insurance Informa | <u>tion</u> | Secondary Inf | <u>Cormation</u> |
| Insurance Name: | e: Insurance Name: | | |
| Subscriber Number: Subscriber Number: | | | |
| Group Number: | | | |
| Insurance Address: | Insurance Address: | | |
| Subscriber's Name: | | | |
| Subscriber's DOB: | | | |
| Subscriber's SS#: | | Subscriber's SS#: | - |
| | Medical I | <u>nformation</u> | |
| Allergies: | | | |
| Pharmacy: | Ad | dress: | |
| Emergency Contact: | Relat | ionship:Pho | ne: |
| | Authorizatio | n and HIPAA | |
| I hereby authorize the release of medica Dermatology Associates, PC. I understa contract. | = | - | |
| Notice of Privacy Practices Acknowle copy of the Dermatology Associates, P. information about me may be used and obtain access to and control of this information. | C. Notice of Privacy Pradisclosed by the medical | ctices and have therefore been advi | sed of how health |
| By signing below, I also consent to the to seek and receive payment for services business associates. | | | |
| Signature (Patient or Parent of a M | inor) | Date | · |