DERMATOLOGY
HIGH VALLEY

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**How did you hear about us? Internet___ Phone Book___ Billboard___ Dr. Referral___ Radio/TV___ Other_____

PATIENT INFORMATION – CONFIDENTIAL

Primary Care Doctor:

Patient Name: Last First			SSN
Address		Apt#	Date of Birth
City	State	ZIP	Sex Assigned At Birth: M F
Home Phone	Cell Phone		Marital Status
Email (portal/appointment reminders)			
Employer		Work Phone	
Spouse/Parent Name Last First			Date of Birth
Address		Apt#	SSN
City	State	ZIP	Home Phone
Employer		Work Phone	

Insurance Information

Primary Insurance		
Policyholder Name	Relation to Patient	Date of Birth

Secondary Insurance		
Policyholder Name	Relation to Patient	Date of Birth

For Minor Patients Only

I authorize High Valley Dermatology to treat minor patients when **NOT** accompanied by a parent or legal guardian.

_____ _____

Signature / Relationship to Patient **Date**

For Medicare Patients Only

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature / Relationship to Patient **Date**

I request authorized insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above insurance carrier(s) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature **Date**