

Did your doctor refer you to our office? NO YES – Name Referring Doctor: _____

How did you hear about us: Doctor____ Family/Friend____ Newspaper____ Internet____
Phone Book____ Radio____ School Ad____/ What School? _____
Other____/ Please List_____

I have received the Notice of Privacy Practices from HOLLAND DERMATOLOGY and understand how my medical information may be used, disclosed and protected. Initial_____ Date_____

Name_____ Male or Female
First MI Last
 Birth Date ____/____/____ Social Security # _____ - _____ - _____
 Address_____ Home Phone (____) _____
 City_____ State_____ Zip_____ Cell Phone (____) _____
 Marital Status: Single Married Divorced Widowed Work Phone (____) _____

May we leave personal medical information on your answering machine/voice mail? YES or NO

In case of an emergency, who should be notified? _____

Relationship: _____ Phone #: (____) _____

If you would like our office to be able to discuss your medical information with family members/friends you MUST provide their information below.

If no one is listed, our office will not be able to give ANY medical information to anyone other than the patient.

Name:_____ Relationship:_____ Phone # _____

Name:_____ Relationship:_____ Phone # _____

Name:_____ Relationship:_____ Phone # _____

Please provide any insurance cards to the receptionist & complete the following insurance information.

Primary – Insurance Company: Ins. Co. Name _____
 Name of Policy Holder (Insured): _____ Holder's Date of Birth: ____/____/____
 Your relationship to Policy Holder (circle one) Self Spouse Dependent
 Policy Holder's Social Security #: _____

Secondary – Insurance Company: Ins. Co. Name _____
 Name of Policy Holder (Insured): _____ Holder's Date of Birth: ____/____/____
 Your relationship to Policy Holder (circle one) Self Spouse Dependent
 Policy Holder's Social Security #: _____

Please Sign So We May Have Your Medicare Authorization On File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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: _____ Date _____ **2011**