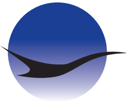

Patient Information Form

Please complete both sides of this form in ink and sign where indicated.

PATIENT INFORMATION

Patient Name (last, first, middle initial) ______________________________ Date ____ / ____ / ______

Date of Birth: ____ / ____ /______ Social Sec. # ____________________ Gender: Male Female

Mailing Address: Street ____

City ____________________________ State __________ ZIP ____________________

Alternate Address: ____

Home Phone (____) ____________ Work Phone (____) ____________ Cell (____) ____________

Email Address: ____

(We will never give out your email address or send personal medical information via email without your permission.)

Name of Referring Physician (Primary Care) ________________________________

Marital Status: (Circle one) Single Married Divorced Widowed Separated

Parent, Spouse or Responsible Party (If different from patient)

Name (last, first, middle initial) ____

Date of Birth ____ / ____ / ______ Social Sec. #______________________ Gender: Male Female

Mailing Address: Street ____

City:______________________ State: ______________ ZIP: ____________________

Alternate Address ____

Home Phone (____) ____________ Work Phone (____) ____________ Cell (____) ____________

Email Address ____

INSURANCE INFORMATION

Insurance Coverage – Primary

Insurance Company Name____

Name of Policy Holder (Insured) ______________________________ Date of Birth ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other ______________________________

Employer ____________________________ Employer Address ____________________________

Insurance Coverage – Secondary (if applicable)

Insurance Company Name ____

Name of Policy Holder (Insured) ______________________________ Date of Birth ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other ______________________________

Employer ____________________________ Employer Address ____________________________

Office use only: Office Location: ______________ Acct Number:______________ Attach a copy of Patient's insurance card(s) (front & back) Staff Initials: ________
Verify Form is completely filled out Staff Initials: ________

Emergency Contact Information

Name of Friend or Relative: ______________________

Relationship to Patient: ______________________

Address: ______________________

____

Daytime Phone: (___) ______________

Evening Phone: (___) ______________

Pharmacy Information

Pharmacy Name: ______________________

Address: ______________________

Phone: ( ) ______________ Fax: (___) ______________

RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

How did you learn about Riverchase?

- ☐ Newspaper (specify) ______________
- ☐ Magazine (specify) ______________
- ☐ Physician Referral (specify) ______________
- ☐ Family/Friend (specify) ______________
- ☐ Phone Book (specify) ______________
- ☐ TV Network (specify) ______________
- ☐ Website/Search Engine (specify) ______________
- ☐ Other (specify) ______________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information to my primary care or referring Physician, to Consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the Riverchase Physician/Provider if applicable.

Responsible Party Signature: ______________________ **Date** ____ / ____ / ______

FOR MEDICARE PATIENTS ONLY

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to Riverchase Dermatology (RCD) for any services furnished to me by providers of RCD. I authorize RCD to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Medicare is not always the Primary insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare;

Yes	No	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness/injury covered by the VA (Veterans Administration)?
☐	☐	Is this illness/injury covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness/injury due to an automobile accident?
☐	☐	Is this illness/injury due to work related causes?

Patient Signature: ______________________ **Date** ____ / ____ / ____

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