Riverchase Dermatology
And Cosmetic Surgery

Patient Information Form

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

PATIENT INFORMATION

Date ____ / ____ / _____

Patient Name (last, first, middle initial) _____ Preferred Name _____

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

Race _____ Ethnicity _____ Language _____ ☐ Decline

Mailing Address: Street _____

City _____ State _____ ZIP _____

Alternate Address: _____

Primary Phone (_____) _____ Alternative Phone (_____) _____

Email Address: _____

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

Please check yes or no to authorize Riverchase Dermatology to contact you via email for appointment reminders, practice updates and informational promotions.

Yes _____ No _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Letter

Primary Care Physician: _____ Referring Physician: _____

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 _____

Primary Phone (_____) _____ Alternative Phone (_____) _____

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/cross roads: _____ zip code: _____

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** ___/ ___/ ____