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: _____

Home Phone: (_____)_____Mobile 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 _____

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## 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) _____

## EMERGENCY CONTACT INFORMATION

Name of Friend or Relative: _____

Relationship to Patient: _____

Address: _____

_____

Home Phone: _____

Mobile Phone: _____

## 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** ___/_____/ _____