GARDEN CITY DERMATOLOGY, PC - PATIENT INFORMATION

Last Name:______________________________Middle Initial_____First Name:_______________________________

Address: ____Apt. #: _____________

City: ___________________________________State____________ Zip:____________________________________

Phone: Home: (____)_________________Work: (____)________________Ext.___ Cell: (___)___ _______________

SS# _______-______- _______Date of Birth:____/___/____ M [ ] F [ ] E-Mail________________________________

Emergency Contact Name:____________________________________Emergency Contact Phone: [___]_______________

Single [ ] Divorced [ ] Widow(er) Married [ ] Spouse Name: ______________________________________

Employer: ____ Address: _______________________________

City & State: ____Phone: __________________________

Referring Doctor: ____Phone: ______________________

Government Mandated Questions:

Ethnicity: [ ] Unknown [ ] Hispanic or Latino [ ] Not Hispanic or Latino
Race: [ ] White [ ] Native American or Other [ ] American Indian or Alaskan [ ] Asian [ ] Black/African American
Language: [ ] English [ ] Spanish [ ] French [ ] Italian [ ] German [ ] Portuguese [ ] Chinese [ ] Japanese

Primary Insurance Company: ____Effective Date: __________

Policy Holder: ___________________________ M[ ] F[ ] SS# _____-_____-_____ Date of Birth: ___/___/____

Policy Holders Address: ____Relationship to Insured _________

Policy Holders Employer & Address____

Secondary Insurance Company: ____Effective Date: _________

Policy Holder: ___________________________ M[ ] F[ ] SS# _____-_____-_____ Date of Birth: ___/___/____

Policy Holders Address: ____Relationship to Insured _________

Policy Holders Employer & Address____

I hereby authorize and direct the above named practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representative therefore to examine and make copies of all records relating to such treatment. Upon request for release of records, I hereby authorize Garden City Dermatology, PC to furnish all records and results to the parties I specify. I hereby assign, transfer and set over the above named practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical cost of care and treatment rendered to myself or my dependent in said practice. I agree to pay all monies, including the full original fee, all $20 administrative fees and 1.8% daily interest so that Garden City Dermatology receives full reimbursement of monies due.. I understand I am responsible for any and all services not covered by my insurance company. I accept responsibility for payment of my account.

SIGNATURE: ____DATE_____________________
(If patient is under 18, Parent or Guardian must sign)