DERMATOLOGY SERVICES, INC.

145 Faunce Corner Mall Road, North Dartmouth, MA 02747 508-993-7601

PATIENT INFORMATION

LAST _____ FIRST _____ MIDDLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ ☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

RACE: ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ DECLINE TO ANSWER

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO ANSWER

LANGUAGE _____

EMAIL ADDRESS: _____

CELL PHONE _____ HOME PHONE _____

BEST NUMBER TO CALL: ☐ CELL ☐ HOME

EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT _____ PHONE _____

PRIMARY CARE PHYSICIAN (PCP)

PRIMARY CARE PHYSICIAN _____

ADDRESS _____

PHARMACY INFORMATION

PHARMACY NAME _____ PHARMACY PHONE _____

PHARMACY ADDRESS _____

INSURANCE INFORMATION

INSURANCE CARRIER NAME _____

POLICY NUMBER _____

INS. SUBSCRIBER ☐ SAME AS PATIENT _____

RELATIONSHIP TO PATIENT _____ SUBSCRIBER DATE OF BIRTH _____

SECONDARY INSURANCE CARRIER NAME _____

POLICY NUMBER _____ INS. SUBSCRIBER _____

RELATIONSHIP TO PATIENT _____ SUBSCRIBER DATE OF BIRTH _____

PRESCRIPTION COVERAGE INFORMATION

INSURANCE NAME _____

POLICY NUMBER _____

BIN NUMBER _____ PCN NUMBER _____

GROUP NUMBER _____

~ PLEASE REVIEW AND SIGN OTHER SIDE ~

RESPONSIBLE PARTY (person responsible for payment)

☐ SAME AS PATIENT

LAST _____ FIRST _____ MIDDLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

IS THIS CURRENT SKIN CONDITION WORK RELATED? ☐ YES ☐ NO

I request payment of authorized Medicare or Insurance benefits on my behalf for any services furnished to me by Dermatology Services, Inc (DSI). I authorize any holder of medical or other information about me to be released to Medicare/Insurance and their agents any information needed to determine these benefits or benefits for related services. I certify that the information on this sheet is correct. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

I authorize DSI to obtain my medication history from the pharmacy.

I authorize DSI to exchange my personal health information with other health care providers using the MA e-highway and/or Modernizing Medicine secure communication system. I also authorize DSI to send text messages, and I understand that I can opt out of text messages at any time.

I also authorize the physicians, nurse practitioners, physician assistants and staff at DSI to perform diagnostic tests and procedures and to undertake such treatment as deemed necessary or advisable in the care of myself or the above-named person. I consent to such procedures as have been explained to me by the provider and which meet my approval.

PLEASE NOTE: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion of the bill at the time of service.

SIGNATURE _____ DATE _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN