JAMES RIVER DERMATOLOGY

How did you hear about our practice? _____

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Method of Contact: □ Home Phone □ Cell Phone □ Work Phone

Home: _____ **Cell**: _____**Work: _____**

Marital Status:□ Single □ Married □ Divorced □ Widowed □ Partner

Email: _____

Primary Care Physician/ Family Doctor: _____

PCP Practice Name/ Location: _____

GUARANTOR/ RESPONSIBLE PARTY:

□ Same as above □ Other

Guarantor Name: _____ Relationship to Patient: _____

Guarantor Address: _____

MEDICATION/ ALLEGRY VERIFICATION

Allergies: _____ □ *No known drug allergies*

Are you allergic Novocaine? □Yes□ No

Current Medications: _____

_____

_____

_____

INSURANCE INFORMATION

Primary Insurance: _____ **ID#:** _____

Policy Holder: □Patient □Other *(Provide Information Below):*

Name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____ **ID#:** _____

Policy Holder: □Patient □Other *(Provide Information Below):*

Name: _____ DOB: _____ SSN: _____

Does your insurance plan require you to have a referral to see a specialist?

□ No □ Yes □ Not Sure

Note: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

PHARMACY INFORMATION

Local Pharmacy: _____ Location:_____ Phone:_____

Mail Order Pharmacy: _____ Phone: _____

EMERGENCY CONTACT:

Name: _____ Phone #(s): _____ Relation: _____

□ Check only if this person is **NOT** to be included in MEDICAL RELEASE section below.

MEDICAL RELEASE:

Please list any additional persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc.):

Name: _____ Phone #(s): _____ Relation: _____

Name: _____ Phone #(s): _____ Relation: _____

Patient/Guarantor Signature: _____Date: _____