

# Advanced Dermatology of Westchester, PLLC

**PATIENT INFORMATION:** New Patient Name Change Address Change**THIS SECTION MUST BE COMPLETED FOR ALL**

Today's Date \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

*Last**First**Middle Initial*Prefer to be called (ID checked )Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex:  Male  Female Social Security#:

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

*Street & Apartment #**City**State**Zip Code*

Home#:( ) \_\_\_\_\_ Cell#:( ) \_\_\_\_\_ Work#:( ) \_\_\_\_\_ Ext:\_\_\_\_\_

How do you prefer to be reached?  Home  Cell  Work or Email Address:\_\_\_\_\_

How did you hear about us?\_\_\_\_\_

Family/Referring Physician Name:\_\_\_\_\_ Phone#:( ) \_\_\_\_\_

**RESPONSIBLE PARTY: (if different from patient)**

Name: \_\_\_\_\_

*Last**First**Middle Initial*

Prefer to be called

Mailing Address: \_\_\_\_\_

*Street & Apartment #**City**State**Zip Code*

Home#:( ) \_\_\_\_\_ Cell#:( ) \_\_\_\_\_ Work#:( ) \_\_\_\_\_ Ext:\_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex:  Male  Female Social Security#:Relationship of Responsible Party to Patient:  Mother  Father  Spouse  Other**INSURANCE COVERAGE - PRIMARY**

Insurance Name:\_\_\_\_\_ Insurance ID#:\_\_\_\_\_ Group#:\_\_\_\_\_

Policy Holder's Name:\_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_

Relationship of Patient to Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_Effective Date of Coverage: \_\_\_/\_\_\_/\_\_\_ Co-pay Amount: \_\_\_\_\_ Referral Required?  yes  no**INSURANCE COVERAGE - SECONDARY**

Insurance Name: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_/\_\_/\_\_

Relationship of Patient to Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_

Effective Date of Coverage: \_\_/\_\_/\_\_ Co-pay Amount: \_\_\_\_\_ Referral Required?  yes  no

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. 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. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: \_\_\_\_\_ Date \_\_/\_\_/\_\_