NEWTON WELLESLEY DERMATOLOGY ASSOCIATES, P.C.

Name_____ Age_____ Date of Birth____/____/____

Address_____ Apt_____

City_____ State_____ Zip_____ Sex: Male____ Female____

Home Phone #_____ Cell #_____ Social Security #_____

Race: ___Black or African American ___American Indian or Alaska Native ___Asian ___Hawaiian or Other Pacific Islander

___Other Race ___White

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ____ Unknown Primary Language:_____

Employment (If patient is a minor, parent's employment information.)

Occupation_____ Employer_____

Work Address_____

City_____ State_____ Zip_____ Phone #_____

Parent's name if patient is a minor: (Mother)_____ (Father)_____

Person to notify in case of an emergency_____ Phone #_____

Primary Care Physician_____ Address_____

Who referred you to this office_____

Insurance Information (please list all companies)

Primary_____ ID#_____ Group #_____

Subscriber_____DOB____/____/____ Relationship_____

Secondary_____ ID#_____ Group #_____

Subscriber_____DOB____/____/____ Relationship_____

Subscribers Social Security #_____

Spouse's Name_____ Spouse's work phone #_____

It is our policy that co-payments be paid at time of service. <u>If we do not bill your insurance carrier directly</u>, we ask that you pay Newton Wellesley Dermatology at the time of service and submit our bill to your insurance company for direct reimbursement.

Please read and sign:
I hereby authorize Newton Wellesley Dermatology Associates to release to my insurer any information pertinent to my examinations or treatment.

Signed_____ (Patient)_____ (Guardian)_____ Date____/____/____