RHEUMATOLOGY & DERMATOLOGY ASSOCIATES, PC

Patient Information

Legal Name: (First, Middle, Last)			Preferred Name:	
Address:		City:	State:	Zip:
Phone Number:	Other Number:	Email:		Would you like to receive our newsletter? Y / N
Date of Birth:	Social Security Number:	Marital Status:		Sex:

Employment / School information

Employed: ☐ Full Time ☐ Part Time Student: ☐ Full Time ☐ Part Time	Employer/School:			Position:
Employer/School Address:	City:	State	Zip:	Phone:

Emergency Information

Person to Contact in Case of Emergency:				Relationship to Patient:
Address:	City:	State	Zip:	Phone:

Responsible Party for Minors

If Patient is a Minor, Responsible Party Name PRESENT WITH CHILD:				Relationship to Patient:
Address:	City:	State	Zip:	Phone:

Referral Information

How were you referred? ☐ Doctor:	Address:		Phone:
☐ Our Website:	☐ Other Website:	☐ Social Media:	☐ Magazine:
☐ Family/Friend	☐ Other:		

Primary Insurance

Policy Holder's Name: (First, Middle, Last)		Patient's Relationship to Policy Holder:		Policy Holder's DOB:	Sex:
Policy Holder's Address:		City:	State:	Zip:	Phone:
Work Phone:	Employer's Name:	Policy Holder's SS #:	Individual ID Number:		Group Number:
Insurance Company Name & Address:					

Secondary Insurance

Policy Holder's Name: (First, Middle, Last)		Patient's Relationship to Policy Holder:		Policy Holder's DOB:	Sex:
Policy Holder's Address:		City:	State:	Zip:	Phone:
Work Phone:	Employer's Name:	Policy Holder's SS #:	Individual ID Number:		Group Number:
Insurance Company Name & Address:					

ATTENTION MILITARY

If your insurance is through the military, please fill out the following information: ☐ Active

Policy Holder SS#: Branch: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard ☐ Retired

Tricare Standard / Tricare Select / Tricare Prime:

Have Referral? ☐ Yes ☐ No If yes, what is your Start Date ____________________ End Date ____________________

Payment Policy

Payment is expected when services are rendered. All bills are ultimately the responsibility of the patient or guardian and not the insurance company. Any delinquent charges or returned checks may be turned over to a collection agency and a $25.00 charge imposed. I authorize the release of medical information to process insurance claims. I authorize payment of medical benefits to the physician for services rendered.

Responsible Party Signature:	Date:

Cancellation Policy

If you need to cancel or reschedule your appointment, please do so in advance of your scheduled appointment time or a $25 fee will be imposed.
I understand the above and by signing agree to the terms of this office.

Print Name:	Signature:

I acknowledge that I have received a copy of the Privacy Practices.

Print Name:	Signature: