



NORTHAMPTON  
**Dermatology**  
 ASSOCIATES

**Patient Information**

HIPAA 2010 \_\_\_\_\_

Patient Full Name \_\_\_\_\_ Mr  Mrs  Ms

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_ Ext \_\_\_\_\_

Birth Date \_\_\_\_\_ S.S.# \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: M  D  S  W

Nature of Skin Problem \_\_\_\_\_ Date of Onset \_\_\_\_\_

Treatment for Skin Problem \_\_\_\_\_

Allergies \_\_\_\_\_

Medical Illnesses 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Medications 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Insurance Information**

Policy Holder Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_ Ext \_\_\_\_\_

Birth Date \_\_\_\_\_ S.S.# \_\_\_\_\_ Sex \_\_\_\_\_

Employed By \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Business Telephone \_\_\_\_\_

Primary Ins Name \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Secondary Ins Name \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Primary Care MD \_\_\_\_\_ Address \_\_\_\_\_

Local Pharmacy \_\_\_\_\_



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## Official Financial Policy

Name and address of responsible party \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We will bill the insurance carrier (as identified above) for all charges for services rendered. Any balance not reimbursed by your insurance carrier will be billed and payable by the "responsible party" as listed above. I understand that I may also be billed directly by a pathology service or laboratory if those services were required during my visit and if there are balances not covered by my insurance. Co-payments are due at the time of the visit. Self Pay patients are required to make full payment at each visit.

I authorize the release of medical information necessary to process claims for medical benefits.

I authorize payment of medical benefits to NORTHAMPTON DERMATOLOGY ASSOCIATES P.C. for services rendered.

I acknowledge I have received a copy of "Notice of Privacy Practices."

Your signature below signifies that you have read and understand the above and that the information you have provided on this form is correct. We will use any of the telephone numbers you have listed above if we need to contact you.

\_\_\_\_\_  
Signature of Patient/Parent

\_\_\_\_\_  
Date