METROPOLITAN DERMATOLOGY
COSMETIC·MEDICAL·SURGICAL

Patient Name: _____ Date: _____
First M.I. Last

Reason(s) for visit: _____

Date of Birth: _____ Age: _____ SS#: _____ _____ **Male or Female**

Address: _____ **Town:** _____

State: _____ **Zip Code:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____

Business Phone: (_____)_____ **E-Mail*:** _____
*By providing this you will automatically be web-enabled with our practice.

Employer Name: _____ **Occupation**: _____

Employment Status: □ Employed Full-Time □ Employed Part-Time □ Unemployed
□ Self Employed □ Retired

Student Status: □ Full-Time Student □ Part-Time Student

Primary Doctor (Name & Town): _____

Pharmacy (Name & Town): _____

Race*: □ Asian □ Black/African American □ Caucasian □ Hispanic □ Other

Ethnicity*: □ Hispanic/Latino □ Not Hispanic/Latino

Preferred Language*: □ English □ Spanish □ Other _____

*Please note these questions are asked to comply with U.S. Government requirements.

How did you hear about our practice? *(Circle all that apply)*
Referring Physician, Family, Friend/Co-worker, Internet, Yellow pages, Insurance directory, Other: _____

Emergency Contact Information

Name: _____

Relationship: _____ Phone: (_____)

Subscriber of Insurance Information

Name: _____ Relation to Patient: _____ D/O/B: _____

Address (If different from above): _____

I agree that my Protected Health Information (PHI) may be shared with the following people:

_____ _____

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION (PHI). WE ARE ALSO REQUIRED TO PROVIDE YOU WITH OUR NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES OUR LEGAL RESPONSIBILITES AND YOUR RIGHTS REGARDING THE USE AND DISCLOSURE OF YOUR PHI. YOUR SIGNATURE BELOW IS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES. (PLEASE ASK FOR YOUR COPY)

Signature: _____ **Date**: _____

I AUTHORIZE; 1. THE USE OF THIS FORM, WHETHER ORIGINAL OR COPY, TO BE USED ON MY INSURANCE AND/OR MEDICARE SUBMISSIONS; 2. RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES INCLUDING MEDICARE; 3. PAYMENT DIRECTLY TO METROPOLITAN DERMATOLOGY (MD) FROM MEDICARE, ALL INSURANCE COMPANIES, AND/OR THIRD PARTY PAYERS; 4. MD TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY AND/OR MEDICARE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO MD. I GIVE PERMISSION TO MD TO FILL OUT THE MEDICARE FORM ON MY BEHALF. I UNDERSTAND THAT MEDICARE AND MOST INSURANCE COMPANIES DO NOT COVER MEDICAL SERVICES THAT ARE DEEMED COSMETIC IN NATURE. THIS INCLUDES, BUT IS NOT LIMITED TO PROCEDURES SUCH AS REMOVAL OF SKIN TAGS, UNSIGHTLY BLOOD VESSELS, SCLEROTHERAPY OF LEG VEINS, BOTOX, SCULPTRA, AND JUVEDERM INJECTIONS.

Print Name: _____

Signature: _____ **Date**: _____