WELCOME

TRI-STATE DERMATOLOGY
2160 SPRINGHILL FURNACE ROAD
SMITHFIELD, PA 15478
PHONE: 724.564.7424

LAST NAME:_____ HOME PHONE: _____

FIRST NAME: _____ MI._____ CELL PHONE: _____

ADDRESS: _____ WORK PHONE:_____

_____ DATE OF BIRTH: _____

CITY: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

STATE: _____ ZIP CODE: _____ SOCIAL SECURITY #:_____

E-MAIL ADDRESS:_____ EMPLOYER & OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S NAME:_____

SOCIAL SECURITY #: _____ SOCIAL SECURITY #: _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S DATE OF BIRTH: _____

EMPLOYER & OCCUPATION: _____ EMPLOYER & OCCUPATION: _____

PHARMACY OF CHOICE: _____ PHONE: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED: _____

PHONE: _____ RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

I authorize the release of medical information to my primary care physician if needed and as necessary to process insurance claims. I also authorize payment of medical benefits to the physician. Our staff is trained to inform you of financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments will be collected. We accept payment in the form of cash, check or credit card.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____

TODAY'S DATE: _____ REFERRED BY: _____