# GOLDMAN DERMATOLOGY, PLLC
## PATIENT INFORMATION FORM

Patient Name:_____

Address:_____Apt:_____

City:_____State:_____ Zip:_____

Employer:_____

Name of Parent or Guardian (if minor):

_____

Referring Physician:_____

or Friend: _____

Referring Physician Phone #:_____

Emergency Contact Name:_____

Relationship to Patient:_____

Emergency Contact #:_____

**PRIMARY INSURANCE**

Insurance Co:_____

Policy #:_____

Group #:_____

Insurance Phone #:_____

If insurance is other than patient's:

Insured Name:_____

Relationship to Patient:_____

Insured's Date of Birth:_____

Insured's SS#:_____

Social Security #:_____

Date of Birth:_____/_____/_____ Gender: ( )M ( ) F

Marital Status: ( ) S ( ) M ( ) D ( ) W

Phone #'s: (H): (_____)_____

(W):(_____)_____

( C ):(_____)_____

E-mail: _____

Permission to contact by E-mail: ( ) yes ( ) no

**PHARMACY INFORMATION**

Pharmacy Name: _____

Pharmacy Phone#: _____

Pharmacy Address: _____

_____

Primary Care Physician:_____

Phone # & Address:_____

_____

_____

**SECONDARY INSURANCE**

Insurance Co:_____

Policy #:_____

Group #:_____

Insurance Phone #:_____

Can we leave messages about lab or biopsy results on your phone? ___Yes ___No
If you would like the doctor to see you alone, please let the medical assistant in the room know.

I hereby authorize GOLDMAN DERMATOLOGY, PLLC to furnish information concerning my illness and treatment to my insurance carriers.
I authorize payment of medical benefits to GOLDMAN DERMATOLOGY, PLLC.
I understand that I am responsible for any part of the charges that are not covered by medical coverage.
I HAVE RECEIVED A COPY OF THE PATIENT PRIVACY NOTICE.

Signed:_____ Date:_____
(Signature of Patient or Parent /Guardian if patient is a minor)

***Please note you can pay your balances and request refills online at www.goldmandermatology.com**