PATIENT INFORMATION

PLEASE COMPLETE THIS FORM IN FULL

Name: (First, Middle Int, Last) _____

Date of Birth: _____ Sex: M F

Address: _____ Marital Status: S M W D

_____

_____

Home Number: _____

Cell Number: _____

Work Number: _____

Social Security: _____

Race: White Black American Indian Mexican Other _____

Ethnicity: Non- Hispanic/Latino Hispanic Latino Other _____

Language: _____

Employer: _____

Occupation: _____

Spouse: _____

Responsible Party: _____

Responsible Party SS #: _____

Responsible Party DOB: _____

Emergency Contact (Not in household): _____

Emergency Contact Phone Number: _____

Medication List

Medications	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Preferred Pharmacy: _____

THIS INFORMATION IS STRICTLY CONFIDENTIAL AND IMPERATIVE FOR YOUR RECORDS - LIFETIME AUTHORIZATION

Assignments of Benefits and Release of Information: I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to Kenneth Hardy, MD/ Pineview Dermatology for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and it its agents, any information needed to determine these benefits payable for related services. I also request that payment of authorized Medigap benefits be made either to me or on my behalf to Kenneth Hardy, MD or Pineview Dermatology for any services furnished to me. I authorize any holder of Medicare and/or insurance information about me to release to Kenneth Hardy, MD, and information needed to determine these benefits payable for related services. **I also understand that I am responsible for non-covered services.**

_____ _____

Patient/Guarantor Signature Date