DERMATOLOGY PROFESSIONALS

1672 S. County Trail, East Greenwich, RI 02818
153 E. Washington Street, North Attleboro, MA 02760

(PLEASE PRINT CLEARLY)

LAST _____ FIRST _____ MIDDLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ AGE _____ ☐ MALE ☐ FEMALE

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ PREFERRED METHOD OF CONTACT:

EMAIL ADDRESS _____ _____HOME _____WORK _____CELL

REFERRING/PRIMARY CARE PHYSICIAN

REFERRING PROVIDER _____
ADDRESS _____
PHONE _____

PRIMARY CARE PHYSICIAN _____
ADDRESS _____
PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER NAME _____

POLICY NUMBER _____ GROUP NUMBER _____

POLICY HOLDER _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER DATE OF BIRTH _____

POLICY HOLDER ADDRESS _____

EMPLOYER _____

SECONDARY INSURANCE CARRIER NAME _____

POLICY NUMBER _____ GROUP NUMBER _____

POLICY HOLDER _____

RELATIONSHIP TO PATIENT _____

POLICY HOLDER DATE OF BIRTH _____

POLICY HOLDER ADDRESS _____

EMPLOYER _____

EMERGENCY CONTACT

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP TO PATIENT: _____ ***PHONE:*** _____

BACKGROUND INFORMATION

Due to recent legislation changes, the government is requiring medical facilities to collect the following information. Please check all that apply:

Primary Language Spoken	**Race**	**Ethnicity**
Chinese ___	American Indian or Alaskan ___	Hispanic or Latino ___
English ___	Asian ___	Not Hispanic or Latino ___
Japanese ___	Black or African American ___	
Spanish ___	Native Hawaiian/Other Pacific Islander____	
Portuguese ___	White ___	
Other: _____	Other _____	

Patient does not know ____ Patient will not provide ____

I request payment of authorized Medicare or Insurance benefits on my behalf for any services furnished to me by Dermatology Professionals, Inc (DPI). I authorize any holder of medical or other information about me to be released to Medicare/Insurance and their agents any information needed to determine these benefits or benefits for related services. I certify that the information on this sheet is correct. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

PLEASE NOTE: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion of the bill at the time of service.

I also authorize the physicians, nurse practitioners, physician assistants and staff at DPI to perform diagnostic tests and procedures and to undertake such treatment as deemed necessary or advisable in the care of myself or the above named person. I consent to such procedures as have been explained to me by the provider and which meet my approval.

SIGNATURE _____ **DATE** _____
(**Patient / Parent-if minor / Guardian**)

A 24-HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. FAILURE TO DO SO MAY RESULT IN A FEE FOR A MISSED APPOINTMENT.