Demographics

Patient Demographics

Legal Name: _____ **Preferred Name**: _____
(Last) (First) (M.I.)

Address: _____ City: _____ State: _____ ZIP: _____

Phone: Home: _____ Work: _____ Cellular: _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security Number: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Are you currently a student? ( ) No ( ) Yes, part-time ( ) Yes, full-time

May our office leave a message on your answering machine/voice mail? ( ) At Home ( ) At Work ( ) On Cell Phone
(Exception: Pathology and lab results will be given only to the patient or designee. Results will not be left on an answering machine.)

If unable to reach you, who, if anyone, may we release medical and/or billing information to? _____
(Name) (Phone Number) (Relationship)

By providing your email address here _____ **you authorize Dermatology Specialists of Omaha to e-mail information** (e-statements, appointment reminders and/or promotional specials/discounts for services.)

Federal Regulations require us to obtain the following information. ***Please check ( ) all that apply***

Ethnicity: ( ) Non Hispanic/Non Latino ( ) Hispanic or Latino ( ) Other or Undetermined _____

Race: ( ) Caucasian ( ) Hispanic ( ) African American ( ) Native American ( ) Asian ( ) Other _____

Language: ( ) English ( ) Spanish ( ) French ( ) German ( ) Mandarin ( ) Vietnamese ( ) Italian ( ) Other _____

Occupation: _____
If retired, please list your former occupation

Employer Name: _____ Employer Address: _____

Family Physician Name and Address: _____

Referred here by: _____
(Name) (Address)

Emergency Contact Person: _____
(Name) (Relationship) (Phone)

_____ _____

Patient, Parent/Legal Guardian, or Power of Attorney Signature Date

Demographics

Insurance and Billing Information

GUARANTOR (Responsible party after insurance) ( ) Same as Patient ( ) Policy Holder ( ) Other-fill in area below

Name: _____ Employer: _____

Address: _____ Phone: _____

_____ Social Security #: _____

City, State, Zip: _____ Date of Birth: _____

INSURANCE COMPANY INFORMATION ***(A copy of your insurance card(s) is needed.)***

Primary Insurance Company: _____ Policy Effective Date: _____ Policy Holder: _____

Secondary Insurance Company: _____ Policy Effective Date: _____ Policy Holder: _____

Tertiary Insurance Company: _____ Policy Effective Date: _____ Policy Holder: _____

PRIMARY INSURANCE POLICYHOLDER INFORMATION ( ) Same as Patient ( ) Other-fill in area below

Name: _____ Date of Birth: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: Home: _____ Work: _____ Social Security Number: _____

Employer Name and Address: _____

SECONDARY INSURANCE POLICYHOLDER INFORMATION ***(If different than above)***

Name: _____ Date of Birth: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: Home: _____ Work: _____ Social Security Number: _____

Employer Name and Address: _____

Has anyone else in your immediate family been seen here? _____
(Patient's name and relationship)

AUTHORIZATION FOR CONSENT TO TREATMENT

I consent to treatment and to the use or disclosure of my protected health information by Dermatology Specialists of Omaha for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills and to conduct the healthcare operations of Dermatology Specialists of Omaha as may be deemed necessary or desirable by my physician, their assistants and designees. This authorization includes, but it not limited to, evaluation, routine diagnostic procedures, laboratory tests, and operative procedures.

I hereby authorize Dermatology Specialists of Omaha to release any medical information to my contacts listed. I hereby authorize Dermatology Specialists of Omaha to leave messages regarding my appointments and balance notices on my voicemail, answering machine, and e-mail as indicated above. I authorize Dermatology Specialists of Omaha to send me information and/or promotional specials to my e-mail address.

I hereby authorize Dermatology Specialists of Omaha to release any medical information to my referring and /or family doctor, and any insurance that is necessary to process and consider health insurance claims. I assign to the doctor all payments for medical services rendered, for which Dermatology Specialists of Omaha participates. I understand that I am financially responsible for all charges, whether or not covered by insurance.

I acknowledge receipt of the Notice of Privacy Practices effective September 18, 2013 from Dermatology Specialists of Omaha, LLC.

_____ _____

Patient, Parent/Legal Guardian, or Power of Attorney Signature Date

We accept cash, checks, Visa, MasterCard and Discover.