Dermatology Consultants at Newton-Wellesley, P.C.

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General Patient Information

Patient Name: ______________________________ Date of Birth: ____________
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address: ____

____

Home Ph: ____________________ Cell Ph: ________________________

Work Ph: ____________________ *Please circle preferred phone number*

Primary Care Name: ________________________ Phone: ________________

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Decline to answer
Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ White
☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander
Language Spoken: ___________
☐ Decline to answer

We will leave appointment reminders on the main contact phone number that you provided at the time of the appointment.

May we leave other medical information on /with:

☐ Home Voicemail ☐ Office Voicemail ☐ Cell Voicemail

Authorization to discuss my appointments and health information:
Name: __________________ Relationship: __________________

☐ I decline to give permission to have anyone to have access to my medical information.

Emergency Contact Info

Name: ________________________

Relationship: ____________________

Home Phone: ___________________

Cell Phone: ____________________

Pharmacy Information

Name: ______________________________ Phone: ______________________

Address: ______________________________ City: ____________ State: ____

Patient Gateway is a free service that allows you to reach us, request appointments, view lab results, set appointment reminders, and more. To set up an account, go to: **www.patientgateway.org** or provide your email address, so that we can register you: Email: ______________________________

HIPAA PRIVACY INFORMATION - Acknowledgement of Notice of Privacy Practices
I have received and/or read the posted notice of the privacy practices at Dermatology Consultants at Newton-Wellesley, PC.

INSURANCE AUTHORIZATION
I hereby authorize and request my insurance company to pay Dermatology Consultants at Newton-Wellesley, PC directly for the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment of the difference. And, if the service provided is considered a non-covered service, I will be responsible for the payment of that service in total.

Although you may have insurance coverage through another person, all billing information will be sent directly to you and will be your responsibility.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries any information needed for this or related claim. I permit a copy of the authorization to be used in place of the original and request payment or medical services to be made to the party who accepts the assignment. I certify that this information is true and correct to the best of my knowledge.

Patient/Guardian Signature: ______________________________ **Date:** ________________