# WELCOME

Please print and fill out this form completely. It will help us to serve you more effectively. If you have any questions any time, please ask us. We are happy to help.

**PATIENT INFORMATION**

Patient Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Home Phone: ______________ Cell Phone: ____________ Sex: ___Male ____ Female

Date of Birth: ___________ Marital Status: ___Married ___Single ___Divorced ___ Widowed

Driver's License #____________________ Social Security ______________

Employer:____________________

Status: __ Full Time __ Part Time __ Retired __ Disability __ Not Employed

Is patient a Student? ________ Full Time or Part time (Circle correct answer)

Referring Physician: ____________________

**INSURED'S INFORMATION**

Insured's Name: ____________________ Relationship to patient: ________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Date of Birth: ____________________ Social Security Number: _____- _______-_____

Employer: ____________________ Sex:___ Male ___ Female

**SECONDARY INSURED INFORMATION**

Insured's Name: ____________________ Relationship to patient: ________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Date of Birth: ____________________ Social Security Number: _____- _______-_____

Employer: ____________________ Sex: ___ Male ___ Female

**EMERGENCY CONTACT INFORMATION**

In the event of an emergency, is there a friend, relative or neighbor we may contact?

Name: ____________________

Home Phone: ____________________ Relationship to patient: ____________________

**INSURANCE INFORMATION Our Receptionist will copy your insurance cards**

- **SEE COPIES OF ATTACHED INSURANCE CARDS**

**Where and when is the best time to reach you?** ____________________

**If you have an answering machine: May we leave your or your dependent's normal test results on machine? YES NO**

**I give my consent for ____________________ to have access to all of my financial and medical records.**

APPLEGARTH DERMATOLOGY, P.C.

| 1861 S. STURDY ROAD<br>VALPARAISO, IN 46383 | 3444 MONROE<br>LAPORTE, IN 46350 |
|---|---|

**I hereby authorize Applegarth Dermatology, P.C. and/or designate to provide medical treatment to me. I authorize Applegarth Dermatology, P.C. and/or designate to release information pertaining to my Treatment for insurance purposes and/or to receive payments otherwise payable to me for services rendered.**

**I understand that I am financially responsible for any and all services rendered by Applegarth Dermatology, P.C. Applegarth Dermatology bills insurance as a courtesy to our patients. I also understand that I am to furnish all necessary information such as policy number and completed insurance forms for any and all services payable by my insurance company so that my insurance may be properly filed.**

**I agree that in the event this account is turned over to our collection agency or our attorney for collection proceedings, I will pay all reasonable attorney and/or collection agency fees, court costs, and that all sums shall be without relief for valuation and appraisement laws.**

______________________________________

PRINTED NAME OF RESPONSIBLE PARTY

| ______________________________________<br>SIGNATURE OF RESPONSIBLE PARTY | ______________________________________<br>DATE |
|---|---|
| ______________________________________<br>SIGNATURE OF WITNESS | ______________________________________<br>DATE |

## MEDICARE AUTHORIZATION

**I request that payment of authorized Medicare benefits be made to Applegarth Dermatology, PC for any physicians services. I authorize any holder of medical or other information about me be released to the Health Care Financing Administration, its agents, any information needed to determine the benefits for related services.**

| ______________________________________<br>SIGNATURE OF MEDICARE BENEFICIARY | ______________________________________<br>DATE |
|---|---|

## MEDIGAP AUTHORIZATION (SECONDARY INSURANCE TO MEDICARE)

**I request that payment of authorized Medigap benefits be made payable to me or on my behalf to Applegarth Dermatology, PC. I authorize any holder of medical or other information about me be released to my Medigap insurance, its agents, any information needed to determine the benefits for related services.**

| ______________________________________<br>SIGNATURE OF INSURED/PATIENT | ______________________________________<br>DATE |
|---|---|

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

**I acknowledge that I have reviewed and have been offered a copy of Applegarth Dermatology, P.C. Notice of Privacy Practices**

| ______________________________________<br>SIGNATURE OF PATIENT | ______________________________________<br>DATE |
|---|---|