HAMPTON DERMATOLOGY, PC

325 Meeting House Lane **(631)283-3131**
Southampton, NY 11968

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Sex _____
Social Security No. _____ Marital Status _____

BILLING ADDRESS:
Street / PO Box _____

City _____

State _____ Zip Code _____

******(please star primary phone number below)******

Home Phone _____

Cell Phone _____

Work Phone _____

LOCAL ADDRESS: (If applicable)
Street / PO Box _____
City _____

State _____ Zip Code _____

Local Phone _____

Employer/ School _____

Email address _____

Emergency Contact _____

Phone _____

INSURANCE INFORMATION: Please Present ALL insurance cards at the front desk at the time of your visit.
Primary Insurance _____ **Secondary Insurance** _____

IF POLICY HOLDER IS *NOT* THE PATIENT *OR* IF PATIENT IS A MINOR, PLEASE FILL OUT THIS SECTION:
POLICY HOLDER / RESPONSIBLE PARTY INFORMATION

*** Policy Holder / Parent** _____ *** Date of Birth** _____ SSN _____

Relationship to patient _____

Home Phone _____

Work Phone _____

Address(if different) _____

City _____

State _____ Zip Code _____

PRIMARY PHYSICIAN: Please Note: If <u>your</u> insurance company requires a referral for specialists. A <u>referral</u> must be filled out by your Primary Doctor.
Name: _____ Phone _____

Address _____

MY PHARMACY: _____ Phone _____

Hampton Dermatology, PC does not participate with all insurance plans. If Hampton Dermatology, PC does not accept my insurance or I have no insurance coverage, I understand that I am expected to pay in full on the day that professional services are rendered, unless other arrangements have been made in advance. If Hampton Dermatology, PC does accept my insurance, I understand that I am responsible for any amount not covered by my insurance, including deductibles and co-payments.

I hereby authorize treatment of my/my dependants medical condition by Hampton Dermatology, PC.

I hereby authorize Hampton Dermatology, PC to furnish information to my insurance plan(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to myself and my dependants. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature _____ Date _____

(TURN PAGE OVER TO CONTINUE)