New Patient Information

Patient Title Dr. Mr. Mrs. Ms.
First Name____________________________ M.I. _____ Last Name____________________________
How do you like to be addressed? _____________________________
Date of Birth ____/_____/______ Age ______ Male Female
If you have a preferred pronoun please indicate _____________
Marital Status: Single Married Divorced Widow Spouse's Name ___________________

Mailing Address ____
City________________________________ State____________________ Zip _____________________
Social Security Number _____________________
Home Phone ____________________ Cell Phone ____________________
Is it ok to leave a detailed voicemail? Yes No
Email ____
Occupation/Employer ____________________________________ Student Part-time Full-time
Primary Doctor Name ________________________________ Location ___________________________
Primary Doctor Phone_________________________ Fax _______________________
Pharmacy Name _______________________ Town ____________________ Phone _______________

Referring Physician (if applicable) ____
How did you hear about us? ____

Insurance Coverage

Note: While OneSkin Dermatology does not participate with ANY insurance carriers including Medicare, it is important that we collect your insurance information in order to comply with government regulations and assist you with your out of network claims submissions or prior authorizations if requested.

I am uninsured

Primary Insurance

Insurance Co. Name ____
Policy Holder (Insured) Name _________________________ Date of Birth ______/______/_______
Policy # ____________________________________Group Name or Number ______________________

***Please present ALL Insurance cards and Driver's License to the receptionist. If patient is a minor, and you are not the legal guardian, please inform receptionist immediately. Thank you.**

Patient Release

MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN

I certify that the information that I have provided is correct. I understand that OneSkin Dermatology does not participate with any insurance plan, including Medicare and Medicaid, and that I am responsible for all payments at the time of service.

I hereby authorize OneSkin Dermatology, its providers and staff, to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required following the initial visit, even if I am not present. I understand additional written consent may be necessary for certain procedures, and, in that event, a legal guardian must be present to provide such consent.

I agree to receive news and information about the practice via email, which may include offers and announcements for special events or offers from the practice and my physician. ______________ (initial)

Patient or Legal Guardian signature: _______________________________ Date: ______________

Name of Legal Guardian if applicable: ____

Patient Name: ____ DOB: _______________