MYSTIC VALLEY
dermatology
ASSOCIATES, P.C.

General Information

Please fill in all missing information, *verify and/or correct any printed information. Please print legibly.*

Patient's Name: _____ **Age:** _____ **Birthdate:** _____
Last First Middle

Address: _____ **E-mail:** _____
Street and Apt Number City State Zip

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext.** _____

Primary contact: *Home / Work / Cell* ***Auth. to E-mail:*** Yes___ No___ ***Auth. to Leave Voicemail:*** Yes___ No___ ***Auth. to Text:*** Yes___ No___

Sex: _____ **Marital Status:** _____ **Race:** _____ **Ethnicity:** _____ **Language:** _____

Referring Physician: _____ **Phone number:** _____

Address: _____
Street and Suite Number City State Zip

Primary Care Physician: _____ **Phone number:** _____

Address: _____
Street and Suite Number City State Zip

Emergency Contact: _____ **Relationship to Patient:** _____

Home Phone: _____ **Work Phone:** _____ **Other Phone:** _____

Parent or Responsible Party: *(If different from patient)* **Name:** _____ **Phone:** _____

Address: _____ **Relationship to patient:** _____
Street and Apt Number City State Zip

Primary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Name of Subscriber: _____ **Subscriber Date of Birth:** _____ **Relationship:** _____

Secondary Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Name of Subscriber: _____ **Subscriber Date of Birth:** _____ **Relationship:** _____

I hereby authorize and assign my insurance benefits to be paid directly to Mystic Valley Dermatology Associates, P.C. I authorize release of information to facilitate treatment, payment or heath care operations. I give Mystic Valley Dermatology Associates, P.C. permission to treat me and take photographs.

Co-payments and/or outstanding balances are due at the time of your appointment. I agree that I will be financially responsible for any treatment I receive, in the event that my insurance company denies payment due to lack of referral. I will be responsible for a $50 fee in the event that: (1) my check is returned for insufficient funds, or: (2) my account is turned over to a collection agency, or; (3) I fail to show for my appointment and have not notified your office at least one full business day in advance of the appointment. My signature below signifies my understanding and agreement to comply with this policy.

I have read and understand the Notice of Privacy Rights and Practices and MVD Policies.

Signature of Patient
(or responsible party) _____ **Date** _____

Optional: I authorize the following person(s) to have access to my medical and financial information. This authorization may be revoked in writing at any time.

Name: _____ Phone number: _____

Name: _____ Phone number: _____

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