MYSTIC VALLEY
DERMATOLOGY ASSOCIATES

# 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:** _____

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**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*

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

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

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

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

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**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:** _____

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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 up for my appointment and have not notified your office at least two business days 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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Medford | Salem, NH | Stoneham | Wilmington | Winchester