



**PATIENT INFORMATION**

**Name: (Mr., Mrs., Ms., Miss., Dr.)** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Cell Number:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Student:** \_\_\_\_\_ Full or Part-time(Circle)

**Email:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

**How did you learn about our office(Who referred you)?** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Primary Insurance Information:**

Insurance company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Subscriber: Self \_\_\_ Spouse \_\_\_ Dependent\_\_\_ SSN: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary Insurance Information:**

Insurance company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Subscriber: Self \_\_\_ Spouse \_\_\_ Dependent\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_



**Bala Dermatology**

**NEW PATIENTS/INSURANCE CHANGES**

**William K. Sherwin, M.D., Ph.D.**

**Mary E. Griffin, D.O. FAAD**

One Bala Plaza • Suite 620, Bala Cynwyd, PA 19004

www.baladermatology.com • Phone: 610.664.3300 • Fax: 610.664.1151

### **PAYMENT AGREEMENT**

I request that payment of authorized benefits be made to Bala Dermatology for any services provided. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

My name below verifies the accuracy of all of the above information including address, phone number, and medical history.

Patient or Authorized Designee Signature: \_\_\_\_\_

---

### **HIPAA NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been provided the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I have been given an opportunity to read the Notice.

I hereby authorize Bala Dermatology to obtain, use and disclose private health information about me to carry out treatment, healthcare operations and to secure payment from my insurance carrier (including Medicare, Blue Shield, Personal Choice, Aetna, Major Medical and all other private insurance carriers). I have the right to review the Notice of Practices prior to signing this consent. Further, I authorize my insurance carrier to make direct payment to Bala Dermatology. I realize I am responsible for deductibles and copayments not covered by private insurance companies.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_