

Welcome to Skin Solutions Dermatology –

Please accurately complete each section of the form below. Any missing information may result in an insurance claim denial. The best contact number will be utilized to confirm upcoming appointments and to leave detailed personal information and results.

**A. Patient Information**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Female Male Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employer Name/Phone #: \_\_\_\_\_

Best Contact Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Can we leave message of results via voice mail? yes  no

Emergency Contact: \_\_\_\_\_ Relation \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I give permission to discuss my personal medical information with:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Yes, I would like to register for Patient Portal so that I may access my medical records and request follow up appointments online.

Email address \_\_\_\_\_ @ \_\_\_\_\_

**B. PCP INFORMATION**

Have you seen a physician that recommended you see a dermatologist for your skin condition? Yes  No

If yes:

Physician name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician:

Physician name \_\_\_\_\_

Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**C. PHARMACY INFORMATION**

Pharmacy Name:

\_\_\_\_\_

Location:

\_\_\_\_\_

Pharmacy Number:

\_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_

**Subscriber ID:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Policy Holder's Name :** \_\_\_\_\_

**Policy Holder's Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder's Social Security #:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder's Relation to Patient:** \_\_\_\_\_

**Responsible Party's Address:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**Subscriber ID:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_

**Policy Holder's Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder's Social Security #:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder's Relation to Patient:** \_\_\_\_\_

I have reviewed and understand the office policy in regards to the **HIPPA Notice of Privacy Practices**. I understand that I may request a personal copy if I so choose.

**Patient or Guarantor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Failure to show for your scheduled appointment will result in a \$25.00 charge to your account. Returned checks will also incur a \$25.00 returned check fee.

Delinquent accounts will be placed in collections and charged an additional 33.3%.

Although it is your responsibility to understand your insurance plan benefits, our staff is dedicated to working with you and your insurance carrier to ensure appropriate reimbursement for your medical bills.

I hereby authorize to release any information, including the diagnosis and record of any treatment or examination rendered to me or my dependent during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Skin Solutions Dermatology. I understand that my insurance carrier may pay less than the actual bill for medical and/or laboratory services. It is my responsibility to notify the nursing station which lab my insurance company contracts with. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent that are not covered by my insurance company.

My signature below acknowledges that I have read all of the above information and understand my obligation.

**Patient or Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Pena MD Studio** offers a variety of services and treatments for your cosmetic needs:  
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- Neck Tightening/Neck Lift
- Neck Lift
- Neck Liposuction
- Dermasculpt
- Laser Hair Removal
- Bi-Lateral Upper Blepharoplasty
- Botox®
- Juvéderm®
- Radiesse®
- Restylane®
- DermaSweep
- Microdermabrasion
- Customized Facials
- Peels
- Latisse™ Eyelash Treatment
- Tinting, Tweezing and Waxing

**How did you learn about us?**

**A friend or family member**

**A physician referral (name):** \_\_\_\_\_

**Internet search (Google, Yahoo, MSN, etc.):**

**My insurance company (name):** \_\_\_\_\_

**Telephone book**

**Marquee (Skin Solutions Exterior Sign)**

**A seminar/event:** \_\_\_\_\_

**Magazine/Newspaper ad:**  
 \_\_\_NFocus      \_\_\_VIP Williamson  
 \_\_\_TPAC/Ballet/Opera Playbill

**Other:** \_\_\_\_\_