

# The Capital Dermatology Medical Group

## New Patient Information Form

Please print

Patient Name \_\_\_\_\_  
Last First

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Daytime Phone ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

Referral Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

In case of emergency, notify? \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Phone

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

Employer's Telephone ( ) \_\_\_\_\_

If patient is a minor, please give name of guardian \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If spouse's address and telephone number are different from patient's, please list below: ( ) \_\_\_\_\_

How did you learn about this practice?

Physician Referral \_\_\_\_\_ Insurance Directory \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Internet \_\_\_\_\_ Other \_\_\_\_\_

**Primary Insurance Information**

Company \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Address \_\_\_\_\_

Patient's relationship to insured \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_

**Secondary Insurance Information**

Company \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Address \_\_\_\_\_

Patient's relationship to insured \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_

The above information is true to the best of my knowledge.

By signing below, I authorize the release of any medical or other information necessary to process claims. I also authorize payment of medical benefits to the physician or practice. I am responsible to pay the deductibles, co-insurance and non-covered services as determined by my insurance policy.

I have received a copy of the Capital Dermatology Medical Group's Notice of Privacy Practices.

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_  
**Date**