DOUGLASTON DERMATOLOGY
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60-40 Marathon Parkway
Douglaston, NY 11362

Patient Information

Name: ______________________________ **Home phone:** __________________

Cell Phone: ___________________________ **Work Phone:** __________________

Email address: (required) ______________________________

Address: ____ **Apt#** _______

City: ______________________________ **State:** ________ **ZIP:** ____________

Date of Birth: _______________ **SS#:** _______-_______-________ **Sex:** ________

Marital Status: Single ________ **Married** _________ **Other** _________

Employer: ___________________________ **Address** _______________________

Primary Care Doctor: ____________________ **Phone #** _____________________

Referred By: Doctor ____ **Relative** ____ **Other Patient** _____ **Insurance Book** _____ **Ad** _____

Name ____________________________ **Phone #** ________________________

Pharmacy Name: ________________ **Pharmacy Address:** ____________________

Pharmacy Phone# _______________ ______________________________

Insurance Policy Holder Information

Name of Insurance: ____________________________ **Referral Needed Y** _____ **N** _____

Name of Policy Holder: ___________________________ **Date Of Birth:** ___________

Sex: M ____ **F** ____ **SS#** ________-______-________ **Relation to you:** _________________

Address if different then above: ________________________________ **Apt#** ________

City ____________________________ **State** ____________ **ZipCode** ____________

I authorize Douglaston Dermatology to furnish all records pertaining to the medical history, service rendered or treatments given to me or my dependent for purpose of insurance claims reviews. I authorize payment of medical benefits to my physician and I accept financial responsibility for services not paid by my insurance including deductibles, co-payments, non-covered services, and any fees not paid by my insurance (for any reason) within 120 days of the date of service.

Patient or Authorized Signature: ______________________________ **Date:** ___________