INTEGRATED DERMATOLOGY
OF TIDEWATER

DATE:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX: ( ) MALE ( ) FEMALE
STREET ADDRESS, CITY, ST, ZIP				
RACE: ( )WHITE ( )HISPANIC/LATINO ( )ASIAN ( )BLACK/AFRICAN AMERICAN ( ) OTHER ( ) DECLINE RESPONSE	HOME #	WORK #	MOBILE #	
MARITAL STATUS: ( )MARRIED ( )SINGLE ( )DIVORCED ( )SEPARATED ( ) WIDOWED ( ) OTHER	EMAIL ADDRESS			

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST	MI	HOME #	MOBILE #
ADDRESS, CITY, ST, ZIP				
EMPLOYER		OCCUPATION		WORK #
EMPLOYER'S ADDRESS, CITY, ST, ZIP				
RELATIONSHIP TO RESPONSIBLE PARTY ( ) SPOUSE ( ) CHILD ( ) OTHER				

REFERRING MD INFORMATION

NAME	PHONE #
SPECIALTY	

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE #
ADDRESS, CITY, ST, ZIP		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	
MEMBER NUMBER	EFFECTIVE DATE
SECONDARY INSURANCE COMPANY	
MEMBER NUMBER	EFFECTIVE DATE

PHARMACY INFORMATION

NAME	PHONE #
ADDRESS , CITY, ST, ZIP	

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of Tidewater LLC of any medical benefits payable to me for the services provided at Integrated Dermatology of Tidewater LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by insurance company. I understand it is my responsibly to pay the balance in full IF the insurance information provided proves false or otherwise ineffective.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to attorney's fees and cost of collection.

I also understand that the automated appointment confirmation system used by IDT will send me an email, call my primary home phone and text me prior to my appointment for confirmation purposes. I also understand that if I do not cancel my appointment within 24 hours of my appointment time I am subject to up to a $50 fee.

Lifetime Signature on File and Lifetime Consent - (for Medicare Patients Only)

I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of Tidewater LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or Secondary insurance benefits be made on my behalf to Integrated Dermatology of Tidewater LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X Date

Patient Signature or Signature of Guardian or Parent