DERMATOLOGY PROFESSIONALS

1672 S. County Trail, East Greenwich, RI 02818
153 E. Washington Street, North Attleboro, MA 02760

(PLEASE PRINT CLEARLY)

LAST ______ FIRST ______ MIDDLE ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

BIRTHDATE ______ AGE ______ ☐ MALE ☐ FEMALE

HOME PHONE ______ WORK PHONE ______

CELL PHONE ______ PREFERRED METHOD OF CONTACT:

EMAIL ADDRESS ______ ____HOME ____WORK ____CELL

REFERRING/PRIMARY CARE PHYSICIAN

REFERRING PROVIDER (IF BEING REFERRED) ______

ADDRESS ______

PHONE ______

****PRIMARY CARE PHYSICIAN***** ______

ADDRESS ______

PHONE ______

INSURANCE INFORMATION

****THIS SECTION MUST BE COMPLETED. WE WILL RETAIN A COPY OF YOUR MOST CURRENT INSURANCE CARD(S) TO KEEP ON FILE AS WELL****

PRIMARY INSURANCE CARRIER NAME ______

POLICY NUMBER ______ POLICY HOLDER NAME: ______

POLICY HOLDER DATE OF BIRTH: ______

GROUP NUMBER ______ RELATIONSHIP TO POLICY HOLDER: ______

POLICY HOLDER ADDRESS ______

EMPLOYER: ______

SECONDARY INSURANCE CARRIER NAME ______

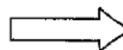
POLICY NUMBER ______ POLICY HOLDER NAME: ______

POLICY HOLDER DATE OF BIRTH: ______

GROUP NUMBER ______ RELATIONSHIP TO POLICY HOLDER: ______

POLICY HOLDER ADDRESS ______

EMPLOYER ______



BACKGROUND INFORMATION

Due to recent legislation changes, the government is requiring medical facilities to collect the following information. Please check all that apply:

Primary Language Spoken	**Race**	**Ethnicity**
Chinese ___	American Indian or Alaskan ___	Hispanic or Latino ___
English ___	Asian ___	Not Hispanic or Latino ___
Japanese ___	Black or African American ___	
Spanish ___	Native Hawaiian/Other Pacific Islander___	
Portuguese ___	White ___	
Other: ________________	Other ______________________	

Patient does not know above info ____ **Patient will not provide ____**

I request payment of authorized Medicare or Insurance benefits on my behalf for any services furnished to me by Dermatology Professionals, Inc (DPI). I authorize any holder of medical or other information about me to be released to Medicare/Insurance and their agents any information needed to determine these benefits or benefits for related services. I certify that the information on this sheet is correct. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

PLEASE NOTE: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion of the bill at the time of service.

I also authorize the physicians, nurse practitioners, physician assistants and staff at DPI to perform diagnostic tests and procedures and to undertake such treatment as deemed necessary or advisable in the care of myself or the above named person. I consent to such procedures as have been explained to me by the provider and which meet my approval.

A 24-HOUR NOTICE IS REQUIRED FOR ALL GENERAL DERMATOLOGY CANCELLATIONS AND A 48-HOUR NOTICE FOR COSMETIC CANCELLATIONS. *FAILURE TO DO SO MAY RESULT IN A FEE FOR A MISSED APPOINTMENT*

SIGNATURE ______________________________________ DATE ______________________

(Patient / Parent -if minor /guardian)