

**MONTGOMERY DERMATOLOGY LLC**  
**PATIENT INFORMATION SHEET- PLEASE PRINT**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SS# \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Cell Phone:(        ) \_\_\_\_\_ Home Phone: (        ) \_\_\_\_\_

e-mail: \_\_\_\_\_ Work Phone: (        ) \_\_\_\_\_

**EMERGENCY CONTACT** Name, Relationship & Phone Number:  
\_\_\_\_\_  
\_\_\_\_\_

**\*PRIMARY CARE PHYSICIAN/ ADDRESS/ PHONE NUMBER:**  
\_\_\_\_\_

**\*PHARMACY NAME/CITY/PHONE NUMBER:** \_\_\_\_\_

<b><u>NAME OF PRIMARY INSURANCE COMPANY:</u></b> _____	
Policy Holder's Name: _____	Policy Holder's D.O.B. _____
Policy Holder's Relationship to the patient (circle one):    Self    Spouse    Parent    Other	
Policy Holder's SS#: _____	Policy Holder's Address: _____
<b><u>NAME OF SECONDARY INSURANCE COMPANY:</u></b> _____	
Policy Holder's Name: _____	Policy Holder's D.O.B. _____
Policy Holder's Relationship to the patient (circle one):    Self    Spouse    Parent    Other	
Policy Holder's SS #: _____	Policy Holder's Address: _____

**CONSENTS & ACKNOWLEDGEMENTS**

With my consent, Montgomery Dermatology, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Our Notice of Privacy Practices is posted and copies are available upon request.

I acknowledge that I have reviewed a copy of Montgomery Dermatology, LLC's Office Policies and Procedures. A copy is available per my request.

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment

**Please list names, relationships, and phone numbers of family members that we may discuss benign or complicated laboratory and/or biopsy results with:**

Name/Number \_\_\_\_\_ Name/Number \_\_\_\_\_

If you **DO NOT** give consent for the following, please check any/all of the boxes below that apply:

- Do not leave normal lab and/or biopsy results with family members or on answering machine
- Do not discuss any lab and/or biopsy results with anyone but the patient or the patient's parent if the patient is a minor.

Preferred phone line for **YOU** to receive biopsy/test results? (Circle one)                      Home / Work / Cell

IS IT OK TO LEAVE A MESSAGE WITH BIOPSY/TEST RESULTS? Circle one    Yes / No

Date: \_\_\_\_\_ Sign Here: \_\_\_\_\_