## FERRARA DERMATOLOGY CLINIC, P.C.

Dr. Richard J. Ferrara Jr., M.D.

**CONFIDENTIAL INSURANCE INFORMATION** 

## **CONFIDENTIAL PATIENT INFORMATION**

Today's Date: \_\_

## (Please present cards for scanning) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female First Name Last Name Middle Initial **Primary Insurance** Address Apt. # Subscriber Name Date of Birth City State Zip Code Contract # Group # ☐ Cell ☐ Home Primary Phone # Address of Subscriber if Different from Patient's ☐ Cell ☐ Home Secondary Phone # City State Zip Code Date of Birth Age Secondary Insurance Patient Social Security Number Subscriber Name Date of Birth E-Mail Address Contract # Group # Student: Full Time Part Time Address of Subscriber if Different from Patient's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed City State Zip Code Patient Employer / School Patient Work Phone Do we have your permission to leave Spouse's Name / Parent's Name (If Minor) a message on your answering service? ☐ Yes ☐ No Who Referred You to Our Office?\_\_\_\_ Do we have your permission to call Who is your Primary Care Physician? \_\_ your place of employment? ☐ Yes ☐ No In Case of Emergency Contact: Contact Name As a service to our patients, we provide courtesy appointment reminder calls/e-mails and possibly other important messages that may be e-mailed or placed using a prerecorded message. Relationship By providing your cell phone number and e-mail you are consenting to receiving such messages. Phone Number Name / Relationship: \_ The Ferrara Dermatology Clinic, P.C. accepts most major insurance plans. All insurance cards presented are verified for eligibility at the time of your visit. HMO patients must present with proper written authorization from their Primary Care Physicians before treatment can be administered. "I authorize my insurance benefits be paid directly to the Ferrara Dermatology Clinic, P.C. for services rendered." Your signature below also authorized the Clinic to release any such medical information necessary to process your insurance claims.

Patient or Authorized Signature