FERRARA DERMATOLOGY CLINIC, P.C.

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

CONFIDENTIAL PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female

Last Name First Name Middle Initial

Address Apt. #

City State Zip Code

Primary Phone # ☐ Cell ☐ Home

Secondary Phone # ☐ Cell ☐ Home

Date of Birth Age

Patient Social Security Number

E-Mail Address

Student: ☐ Full Time ☐ Part Time

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Patient Employer / School

Patient Work Phone

Spouse's Name / Parent's Name (If Minor)

Who Referred You to Our Office? _____

Who is your Primary Care Physician? _____

In Case of Emergency Contact:

Contact Name

Relationship

Phone Number

May we release medical information to family member? ☐ Yes ☐ No

Name / Relationship: _____

CONFIDENTIAL INSURANCE INFORMATION

(Please present cards for scanning)

Primary Insurance

Subscriber Name Date of Birth

Contract # Group #

Address of Subscriber if Different from Patient's

City State Zip Code

Secondary Insurance

Subscriber Name Date of Birth

Contract # Group #

Address of Subscriber if Different from Patient's

City State Zip Code

Do we have your permission to leave a message on your answering service? ☐ Yes ☐ No

Do we have your permission to call your place of employment? ☐ Yes ☐ No

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. By providing your cell phone number and e-mail you are consenting to receiving such messages.

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.

Today's Date: _____

_____

Patient or Authorized Signature