

**CENTRAL CAROLINA DERMATOLOGY CLINIC, INC.
NEW PATIENT INFORMATION**

DATE: _____

FULL NAME: _____
(FIRST) (MIDDLE) (LAST)

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SEX: MALE/FEMALE MARITAL STATUS: M / S / W / D

SOCIAL SECURITY NUMBER: _____ REFERRED BY _____

EMPLOYER _____ WORK PHONE: _____

EMPLOYER'S ADDRESS _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

EMERGENCY CONTACT _____ CELL PHONE _____

ADDRESS _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____

PLEASE READ AND SIGN FOR ANY INSURANCE PAYMENT(S) AND / OR INSURANCE INQUIRIES.

I request that payment of any insurance benefits be made on my behalf to Central Carolina Dermatology Clinic, Inc., for any services furnished to me by that physician. I authorize any holder of medical information about me to release to my insurance company or the Health Care Financing Administration or its agents and information needed to determine these benefits or the benefits payable for related services. I agree to be responsible for payment of all charges not covered or unauthorized by my insurance carrier, as well as, any associated court costs, collection fees, or other remedies required to collect delinquent accounts. This agreement is valid until I cancel it in writing.

SIGNATURE _____ DATE _____

**Acknowledgement of Receipt
Of Notice of Privacy Practices**

I have reviewed the Notice of Privacy Practices for the above named practice and understand that I may have a copy to take with me.

SIGNATURE _____ DATE _____