



Demographics



### Patient Demographics and Insurance Information

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
(Last) (First) (M.I.)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cellular: \_\_\_\_\_

By providing your email address here \_\_\_\_\_ you authorize Dermatology Specialists of Omaha to e-mail information (e-statements, appointment reminders) and/or promotional specials/discounts for services.

May our office leave a message on your answering machine/voice mail? ( ) At Home ( ) At Work ( ) On Cellular Phone  
(Exception: Pathology and lab results will be given only to the patient or designee. Results will not be left on an answering machine.)

If unable to reach you, who, if anyone, may we release medical and/or billing information to? \_\_\_\_\_  
(Name) (Phone Number) (Relationship)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Are you currently a student? ( ) No ( ) Yes, part-time ( ) Yes, full-time

Occupation: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
If retired, please list your former occupation.

Employer Name and Address: \_\_\_\_\_

Family Physician Name and Address: \_\_\_\_\_

Referred here by: \_\_\_\_\_  
(Name) (Address)

Emergency Contact Person: \_\_\_\_\_  
(Name) (Relationship) (Phone)

#### INSURANCE COMPANY INFORMATION (A copy of your insurance card is needed.)

Primary Insurance Company: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

#### Guarantor (Responsible Party) ( ) Same As Patient ( ) Policy Holder ( ) Other – fill in area below

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

#### INSURANCE POLICYHOLDER INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Has anyone else in your immediate family been seen here? \_\_\_\_\_  
(Patient's name and relationship)

#### AUTHORIZATION FOR CONSENT TO TREATMENT

I consent to treatment and to the use or disclosure of my protected health information by Dermatology Specialists of Omaha for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills and to conduct the healthcare operations of Dermatology Specialists of Omaha as may be deemed necessary or desirable by my physician, their assistants and designees. This authorization includes, but it not limited to, evaluation, routine diagnostic procedures, laboratory tests, and operative procedures.

I hereby authorize Dermatology Specialists of Omaha to release any medical information to my contacts listed. I hereby authorize Dermatology Specialists of Omaha to leave messages regarding my appointments and balance notices on my voicemail, answering machine, and e-mail as indicated above. I authorize Dermatology Specialists of Omaha to send me information and/or promotional specials to my e-mail address.

I hereby authorize Dermatology Specialists of Omaha to release any medical information to my referring and/or family doctor, and any insurance that is necessary to process and consider health insurance claims. I assign to the doctor all payments for medical services rendered, for which Dermatology Specialists of Omaha participates. I understand that I am financially responsible for all charges, whether or not covered by insurance.

I acknowledge receipt of the Notice of Privacy Practices effective April 14, 2003 from Dermatology Specialists of Omaha

\_\_\_\_\_  
Patient, Parent/Legal Guardian, or Power of Attorney Signature

\_\_\_\_\_  
Date