Demographics and Consent Form

Name:_____ Age:_____ DOB:_____ Sex:_____

Address:_____ Please complete if applicable (**Responsible Party**):

City/State:_____ Spouse / Partner:_____

Zip:_____ SSN:_____ SSN:_____ DOB:_____

Home#:_____ Cell:_____ Employer:_____

Work#:_____ Phone:_____ Cell:_____

Emergency Contact:_____ Relationship:_____

Home#_____Work#_____**Cell#**_____

Primary Care Doctor _____Referred by Doctor_____

Referring Provider Address: _____

City/State:_____ Zip:_____

Pharmacy Name:_____**Address:**_____

Pharmacy Number:_____

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Subscriber's name: _____ Subscriber's name: _____

Subscriber's DOB: _____ Subscriber's DOB: _____

Subscriber's SSN: _____ Subscriber's SSN: _____

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Policy Number/Goup #: _____ Policy Number/Group #: _____

Copay: _____ Copay: _____

Payment Agreement

Medicare Patients:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me at Dermatology Associates of South Jersey, LLC including physician services. I authorize any holder of medical information about me to release to the Centers of Medicare and its agents any information needed to determine these benefits or benefits payable for related service.

All Patients:

PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, Visa and Mastercard. I understand that there will be a twenty- five dollar fee for appointments not kept and appointments cancelled with less than twenty-four hours notice. I also understand that there will be a thirty-five dollar fee for all returned checks. Your signature below indicates that you accept these policies. Further, your signature authorizes Dermatology Associates of South Jersey to release such medical information necessary to process your insurance claims (if any). I herein authorize payment of medical benefits to DASJ when an assigned claim is filed.

Signature of Patient or Legal Guardian:_____ Date:_____

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