Alamance Skin Center
Partnering for exceptional care.
1734 Westbrook Ave. • Burlington, NC 27215

Patient Information Sheet

Chart #_____

Last Name _____ **First** _____ **Middle Initial**_____

Home Address _____ **City**_____ **State**_____ **Zip**_____

Mailing Address (If different from above) _____ **Email address**_____

Phone Numbers: Home _____ Work _____ Cell_____

Preferred Contact for Biopsy results: _____Home # _____Cell # _____Work # _____ By Email

If you are unavailable when called for biopsy results, may we leave a detailed message? _____Yes _____ No

Date of Birth _____ **Age** _____ **Sex** ( ) Male ( ) Female **Marital Status** _____

Race _____ **Ethnicity** ____Hispanic ____ Not Hispanic **Preferred Language** _____

Social Security Number _____ **Driver's License Number** _____ **State**_____

Employer Name & Address _____

Spouse Information: Name _____ Work #_____ Cell # _____

Employer Name & Address _____

WE MUST RECEIVE COMPLETE INFORMATION IN ORDER TO FILE WITH INSURANCE!!

Primary Insurance Company _____ Policy Holder's Name _____

Subscriber ID # _____ Group # _____ Relation to patient _____

Policy Holder's Date of Birth _____ Policy Holder's Employer _____

Secondary Insurance Company _____ Policy Holder's Name _____

Subscriber ID # _____ Group # _____ Relation to patient _____

Policy Holder's Date of Birth _____ Policy Holder's Employer _____

IF PATIENT IS A MINOR OR DEPENDENT, please list adult/insured party responsible for payment

Name _____ **Relationship to patient** _____ **Phone #** _____

Policy Holder's Employer Name & Address _____

Were you referred by another physician? yes _____ no _____ **Physician's Name** _____

Please read and sign the following:

*I authorize Alamance Skin Center to release to my insurance company any information acquired in the course of my examination and treatment regarding my condition. **** Insured Signature*** _____ ***Date*** _____

*I hereby authorize payment from my insurance company directly to Alamance Skin Center and accept full responsibility for any portion of the charge not paid for by my insurance company for all services rendered to me in the course of my treatment.

****Insured Signature***_____ ***Date*** _____

*I hereby authorize Alamance Skin Center to leave my biopsy results on either my voicemail number _____ or *email* _____ if Alamance Skin Center is unable to reach me.

****Patient Signature*** _____ ***Date*** _____

*I have reviewed a copy of Alamance Skin Center's Notice of Privacy Practices & may request a copy.

****Patient Signature*** _____ ***Date*** _____

*By listing the name of an individual or physician you are giving permission for that party to receive information about the care of the above-named patient. This permission includes picking up prescriptions, sample products, etc.

(1)_____ (2)_____

Emergency Contact Name/ Relationship/ Phone #_____

Revised: 4/19/2019