Central Carolina Dermatology Clinic, Inc.
New Patient Information

Date_____

Full Name_____
First **Middle** **Last**

Street Address_____

City/State/Zip_____

Home Phone_____ **Cell Phone**_____

Email Address_____

Date of Birth_____ **Sex: Male/Female**

Social Security Number_____ **Marital Status: M / S / W / D**

Employer_____ ***Work Phone***_____

Employer's Address_____

Primary Insurance_____

Secondary Insurance_____

Referred by _____

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.

Signature_____ **Date**_____