

Appointment Information – New River Dermatology Date: Appt Time: Appt Purpose:	Co-Pay Information – Co-Pay Amount: Amount Paid: Method:
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Name:	
Street Address:	City:
State:	Zip Code:
Home Telephone:	Date of Birth:
Mobile Telephone:	Age:
Work Telephone:	Social Security #:
Email Address:	Gender:
	Occupation / Employer:

Primary Name on Insurance Policy:	Company:
Billing Address (if different):	
Phone #:	
Relationship:	Date of Birth:

Emergency Contact Information	Primary Care Physician:
Name:	Referring Physician:
Relationship:	Preferred Pharmacy:
Phone #:	Pharmacy Location:
Work Phone #:	Pharmacy Phone:
	Alt Pharmacy:

Primary Areas of Concern for Today's Visit:
1. _____
2. _____
3. _____

I hereby authorize NEW RIVER DERMATOLOGY PLC to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed above. I authorize payment for these services to be made directly to NEW RIVER DERMATOLOGY PLC.

I also understand that I am responsible for payment of services not covered by my insurance company and that payment for co-pays are required at the time of service.

Signature of responsible party: _____ Date: ____/____/____

Printed Name (if not patient): _____

Follow Up Appointment (Office Use Only):	<input type="checkbox"/> Patient Handout Printed	<input type="checkbox"/> E-Rx Printed
Please schedule patient to return for: _____	<input type="checkbox"/> With Nurse	
In _____ <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months; <input type="checkbox"/> as needed; <input type="checkbox"/> as scheduled	<input type="checkbox"/> With Provider	