DERMATOLOGY ASSOCIATES OF WESTERN PENNSYLVANIA

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DEMOGRAPHICS

Name: _____ Date of Birth: _____ Age: _____ Sex: ___M ___F

Mailing Address: _____ City _____ State _____ Zip _____

Email: _____ S. S. #: _____-_____-_____

Insurance Policy Holder: _____ Relationship: _____ DOB: _____

PATIENT RELEASE OF INFORMATION

Patient Phone Numbers:

_____-_____-_____ (Cell) _____-_____-_____ (Home) _____-_____-_____ (Business)

In order to reach patients in a timely manner, we may need to leave a message concerning pathology and laboratory results, prescriptions, special instructions, financial matters etc. Where may we leave a detailed message?* **Check All That Apply:

____ Cell Voice Mail

____ Home Answering Machine

____ Business Voice Mail

____ My Spouse His/Her Name_____ Phone: _____-_____-_____

____ My Parent His/Her Name_____ Phone: _____-_____-_____

____ My Child His/Her Name_____ Phone: _____-_____-_____

____ Other _____ Phone:_____-_____-_____

*** OTHER MEDICAL DOCTORS/PROVIDERS***

Primary Care Doctor: _____ Office Phone: _____-_____-_____

Mailing Address: _____ City _____ State _____ Zip _____

Referring Doctor (if applicable): _____ Office Phone: _____-_____-_____

Mailing Address: _____ City _____ State _____ Zip _____

*** REFERRAL SOURCE ***

How did you learn about our practice?

____ Family ____ My Primary Care Provider

____ Friend ____ Other Medical Professional, please identify: _____

____ Internet Search ____ Existing Patient

____ wpaderm.com ____ Other, please specify: _____

I authorize this office to communicate with other physician's offices, pharmacies, laboratories, and insurance companies that are pertinent to my care. I have read and understand the above statement.

Signature: _____ **Date: _____** **Rev. 8-17-23**