

**Dermatologists of Southwest Ohio, Inc.**

5300 Far Hills Ave  
Dayton Ohio 45429  
Patient Information

ACCOUNT NUMBER

Have you ever been seen by one of our physicians? Yes \_\_\_ No \_\_\_ Physician Name(s) \_\_\_\_\_

Office \_\_\_\_\_ Year \_\_\_\_\_

If your name has changed, your previous name: \_\_\_\_\_

Name: \_\_\_\_\_ M F S M W D  
First Middle Last Sex Marital Status

Address: \_\_\_\_\_  
Street City State Zip Code

( ) ( )  
Home Telephone Emergency Telephone Contact Name E-Mail Address

Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No: \_\_\_\_\_ Race \_\_\_\_\_

Occupation: \_\_\_\_\_ Previous occupation if retired: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Place of employment or school: \_\_\_\_\_

Family Physician: \_\_\_\_\_

**Person Responsible For Payment if Other Than Patient**

Billing Name: \_\_\_\_\_ S. S. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**How did you hear about us?**

Physician Name \_\_\_\_\_

Friend \_\_\_\_\_ Insurance Company \_\_\_\_\_

Commercial  Radio  Newspaper

Has any member of your family been seen here before? \_\_\_ Yes \_\_\_ No

Name of Family Member \_\_\_\_\_

Patient Name \_\_\_\_\_

**Please show us your insurance card so we may make a copy of it for your chart**

Does your insurance require a referral  Yes  No Name and address of referring Physician \_\_\_\_\_

**Primary Insurance (1<sup>st</sup> Insurance)**

**Insurance (Primary)** \_\_\_\_\_

Insurance Effective Date \_\_\_\_\_ Insurance Phone No: \_\_\_\_\_

Subscriber's Name and Address (if different from above)  
\_\_\_\_\_

Employers name \_\_\_\_\_

Subscriber's Policy Number \_\_\_\_\_ Group No. \_\_\_\_\_ Specialty Co-Pay \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

**Insurance (Secondary)**

**Insurance (Secondary)** \_\_\_\_\_

Insurance Effective Date \_\_\_\_\_ Insurance Phone No: \_\_\_\_\_

Subscriber's Name and Address (if different from above)  
\_\_\_\_\_

Employers name \_\_\_\_\_

Subscriber's Policy Number \_\_\_\_\_ Group No. \_\_\_\_\_ Specialty Co-Pay \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_

**Insurance (Tertiary)**

**Insurance (Tertiary)** \_\_\_\_\_

Insurance Effective Date \_\_\_\_\_ Insurance Phone No: \_\_\_\_\_

Subscriber's Name and Address (if different from above) \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

**Deductible Information**

Do you have a high deductible plan	Yes	No	
If yes, how much?			\$ _____
How much of the 2009 deductible is met to date?			\$ _____
Do you have a health savings account	Yes	No	

**Due to changes in insurance policies co-pays, deductibles and any amount not covered by insurance will be requested at the time of service or billed to the patient. This policy covers all physicians of the practice.**

**Insurance Authorization and Assignment**

Authorization is hereby granted Dermatologists of Southwest Ohio, Inc., its medical staff, and other personnel to obtain and release to my insurance company and/or third party payor such information, including medical records, as may be necessary for the completion of my present and future treatment claims. I hereby assign to the physician(s) all payment for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by Insurance.

**Signature of Responsible Party X** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dermatologists of Southwest Ohio, Inc.**

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**List all allergies including medication allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all health problems/Diseases, including Skin:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all Medications you are currently taking, including non-prescription:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all Family History of Medical Problems(Mother, Father, Siblings):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List Past Surgeries and Year:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you tested positive for Tuberculosis : yes \_\_\_\_\_ no \_\_\_\_\_**

**Do you smoke: Yes \_\_\_\_\_ No \_\_\_\_\_ if yes how much \_\_\_\_\_ pack/day**

**Smokeless Tobacco: Yes \_\_\_\_\_ No \_\_\_\_\_ if yes how much \_\_\_\_\_ per/day**

**Alcohol Intake: \_\_\_\_\_ weekly**

**Other \_\_\_\_\_**

**Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_**