cumberland SKIN
surgery and dermatology

BASIC INFORMATION

Name ____ Preferred Name ________________________

Home Address____State ___________ ZIP Code ____________

Home Phone Number (   ) ________________ Cell Phone Number (   ) ______________________________

Birth Date ___ /___/___ SSN _____________________ E-Mail____________________________________

Patient Employer Name ____ Phone (   )____________________

Pharmacy Name & Address ______________________________________City __________________________

Who is your Primary Care Physician? ____________________________City & State______________________

Preferred Language (please circle) English Spanish Hebrew French Other________ Decline to Answer
Ethnicity (please check) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Emergency Contact:___________________ Phone: (   )__________________Relationship:______________

Who may we speak to regarding your medical condition?

Contact: ______________________________ Phone:_________________Relationship:_____________________
Contact:______________________________ Phone:_________________Relationship:_____________________
You will automatically be called, texted or e-mailed for appointment reminders.

INSURANCE INFORMATION

☐ Yes – I have insurance coverage. Please file to the insurance plan listed below.
☐ No – I have NO insurance coverage and have made payment arrangements.

*Primary Insurance Company Name: ___________________________________ Network _____________________

Employer ________________________ Policy Holder Name _______________________ DOB _____/______/______
Relationship to policy holder (circle one) Self Spouse Child Other

*Secondary Insurance Company Name: ___________________________________ Network ___________________

Employer ________________________ Policy Holder Name ________________________ DOB _____/______/______
Relationship to policy holder (circle one) Self Spouse Child Other

RELEASE AUTHORIZATION

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize payment of insurance benefits directly to Cumberland Skin Surgery & Dermatology.
HIPPA INFORMATION: Your medical information disclosed will be used and forwarded in order to provide continuing treatment or care, filing your claims, and all other healthcare operations only.

Patient/Guardian Signature ____ Date ______________________

Print Name ____ Date of Birth _______________