Adams Street Dermatology Associates
36 Adams Street
Quincy, MA 02169
Telephone: 617-773-0711 Fax: 617-376-2271

Patient Information

Name: _____ D.O.B: _____ Gender (Please Circle): Male Female

Home Telephone#:_____Cell Phone#:_____ Email Address: _____

Home Address: _____

Marital Status (Please Circle): Single Married Widowed Separated Divorced

Employer: _____ Employer Telephone #:_____

Emergency Contact/Relationship: _____ Telephone #:_____

Primary Care Doctor: _____ Address: _____ Tel #: _____

Do we have permission to: (Please Circle)

- **Leave message on your preferred telephone number? Yes No**
- **Leave a message at your place of employment? Yes No**
- **Discuss your medical condition with a member of your household? Yes No**

If yes, whom _____ Relationship: _____ Telephone #:_____

Insurance Information

Primary Insurance Name: _____ Identification No._____

Policy Holder's Name & Date of Birth: _____

Secondary Insurance Name: _____ Identification No. _____

Policy Holder's Name & Date of Birth: _____

Information & Assignment of Benefits

I authorize the release of medical information to my Primary Care or referring physician, to consultants, if needed to process insurance claims. I also authorize payment of medical benefits to the health care provider.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand that you are not required to agree to my requested restrictions.

I have presented my insurance cards to the receptionist so they may be scanned into the Practice Management System.

Patient Signature/Guardian_____ Date: _____