Hancock Dermatology

Dr. Lori Sanford
300 E. Boyd Avenue
Greenfield, IN 46140

317-967-7921 Phone
317-967-7122 Fax

Patient Information

Last Name: _____ First Name: _____Middle Initial: _____
Date of Birth: _____ Sex: ____ Social Security Number: _____
Home Phone Number: _____Cell Phone: _____Best Contact: Home or Cell

Can a message be left on your best contact answering machine? Yes or No

Email Address: _____ Can we email? Yes or No

Address: _____ City: _____ State: _____ Zip: _____
Marital Status: Single Married Widowed Divorced
Employer/School: _____ Phone _____

Names of other family members treated in this office: _____
Have you seen Dr. Sanford previously? Yes or No

Responsible Party Information (if other than patient)

Last Name: _____ First Name: _____Middle Initial: _____
Date of Birth: _____ Sex: ____ Social Security Number: _____
Relationship to Patient: _____ Phone: _____

Primary Insurance Company _____
Policy Number: _____ Group Number: _____
Secondary Insurance Company: _____
Policy Number: _____ Group Number: _____

If patient is a minor or full time student

Father's or Guardians Information
Name: _____ Phone: _____
Address: _____
Employer: _____ Phone: _____
Birth Date: _____ SSN: _____

Mother's or Guardian Information
Name: _____ Phone: _____
Address: _____
Employer: _____ Phone: _____
Birth Date: _____ SSN: _____

Emergency Contact Information

Last Name: _____ First Name: _____Middle Initial: _____

Relationship: _____ Phone Number: _____

Physician/Pharmacy Information

Referring Physician: _____ Phone: _____

Family Physician: _____ Phone: _____

Pharmacy Name: _____Cross Streets: _____ Phone: _____

Release of Information

I give my permission for all my medical information to be released to the following people:

Name/Phone: _____ Relationship: _____

I hereby assign my insurance benefits to be paid directly to Hancock Dermatology. I am aware I am financially responsible for **ALL** **NON-COVERED** services. I also authorize the physician to release my information required to process my claim to my employer or insurance company.

I understand that all charges are to be paid at the time of service unless I present a valid insurance card that represents insurance carriers with whom Hancock Dermatology has contractual agreements with. All deductibles, co-pays, and non-covered services area expected to be paid at the time of service. I also understand that if my insurance does not pay my claim within 60 days of billing, I am financially responsible. All balances that go over 90 days are subject to placement with a collection agency. If my account is turned over to an outside collection agency, I agree to be responsible for all costs of collection including but not limited to interest charges at the current legal rate, reasonable attorney fees and court costs. Furthermore, I understand that I may be dismissed as a patient.

Signature of patient/Responsible Party _____Date:_____

Printed Name of Patient/Responsible Party: _____Date: _____

In the case of children, whose responsible party is someone other than the custodial parent, we must ask for that payment for co-pays, ect. be made at the time of service by the person accompanying the child to the office.

If the patient is a minor, I authorize Dr. Lori Sanford to examine and treat my child.

Signature of Parent/Legal Guardian _____ Date: _____

Printed Name of Parent/Legal Guardian: _____ Date: _____

I acknowledge that I have received a copy of the Health Insurance Portability and Accountability Act (HIPPA Privacy Act.)

Signature of Patient/Responsible Party: _____

Date: _____