

# Pioneer Valley Dermatology, p.c.

Richard M. Wyatt, M.D., Ph. D

## Patient Information

LAST NAME												FIRST NAME												M. I.			
PERMANENT/BILLING ADDRESS																											
CITY												STATE		ZIP CODE				SEX									
AREA CODE						PHONE NO.						AREA CODE						PHONE NO.									
Contact												Alternate #															
Phone #												√ if work #															
DATE OF BIRTH												SOCIAL SECURITY NO.												MARITAL STATUS		STUDENT	
MO		DA		YR														S M D P W		FULL TIME		PART TIME					
EMPLOYER -- OCCUPATION																											

Check here if the patient is a Minor or a College Student filing as a dependant

**Minors & College Students filing as dependants:** Provide Parent/Guardian name, phone #, relation to self/patient

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## Insurance Information

**Please provide your insurance information in addition to the copy of your card**

INSURANCE COMPANY NAME												SUBSCRIBER NAME												SUBSCRIBER DATE OF BIRTH		
																								MO	DA	YR

*IF APPLICABLE:*

SECOND INSURANCE CO. NAME												SUBSCRIBER NAME												SUBSCRIBER DATE OF BIRTH		
																								MO	DA	YR

### Primary Care Physician Information

PHYSICIAN NAME												NAME OF PRACTICE											
CITY AND STATE												PHONE NUMBER											

**Are you applying for workers compensation? If yes, please see the receptionist.**

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS: I hereby authorize Pioneer Valley Dermatology, p.c., Richard M. Wyatt, M.D., to release any information acquired in the course of my examination or treatment to my insurance carrier. **I understand that I am financially responsible for charges not covered by this insurance, whether due to lack of referral and/or insurance card, or any other circumstances.** I hereby authorize payment (if applicable) directly to Pioneer Valley Dermatology, p.c., Richard M. Wyatt, M.D., for these charges.

Date      /      / 2009 Signed \_\_\_\_\_  
 Patient or Parent/Legal Guardian if under 18

Date      /      / 2010 Signed \_\_\_\_\_  
 Patient or Parent/Legal Guardian if under 18

Date      /      / 2011 Signed \_\_\_\_\_  
 Patient or Parent/Legal Guardian if under 18