

# 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 Phone #												Alternate #												√ 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 dependent

**Minors & College Students filing as dependents:** 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     /    /     2012 Signed \_\_\_\_\_  
 Patient or Parent/Legal Guardian if under 18

Date     /    /     2013 Signed \_\_\_\_\_  
 Patient or Parent/Legal Guardian if under 18

Date     /    /     2014 Signed \_\_\_\_\_  
 Patient or Parent/Legal Guardian if under 18