PATIENT INFORMATION SHEET

Last Name: __________________________ *First Name:* ___________________________ *MI:*_____ *Age:* _________

Date of birth: ______________________ *SS#* _______-_____-_________ *(for insurance billing)* *Sex: Male/Female*

Mailing Address:

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Phone numbers:
*Home:*____________________________ *Cell:* ________________________ *Work:*__________________________

Email address: ____

*Referring physician (First & last name) & phone number:*____

New Patient? Yes ______ *No:*_______ *How did you hear about our practice?* _______________________________

*Other family members who are patients at our practice:*____

INSURANCE INFO:

Name of insurance: ____

If no insurance, person who is responsible for bill: ____

An office visit includes consultation with the provider and prescriptions for medications. For this service you pay a fee or co-payment. Procedures may be considered surgery and require deductible payment. Some procedures may be considered cosmetic and not covered. Payment is collected at time of service. I authorize payment of medical benefits to Verghese & Ling MD., PA./Mid-Atlantic Skin Surgery Institute for services rendered. I understand that a claim will be filed in my behalf; however, I am financially responsible for charges not covered by my insurance benefits.
I have reviewed the office's notice of privacy practices (HIPAA) (available on the website and in the office). This explains how medical information will be used and disclosed. I understand that I may receive a copy of this document if requested.

____ ___________________________________

Signature of patient/or guardian *Date*