Pioneer Valley Dermatology, PC
29B COTTAGE STREET, AMHERST, MASSACHUSETTS 01002
(413) 549-7400
FAX (413) 549-7402

ESTABLISHED PATIENT INFORMATION SHEET

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SEX: M_____ F_____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Please check off the preferred method for us to contact you: Cell _____ Home _____ Work _____

Social Security #: _____-_____-_____

Primary Care Provider: _____

What is your preferred pharmacy? _____

CONSENT FOR TREATMENT: I authorize Pioneer Valley Dermatology, PC and/or their designee to examine, treat and perform any diagnostic testing or certain procedures on me in the office which he/she deems necessary to properly evaluate my condition.
ASSIGNMENTS OF BENEFITS: I authorize the release of medical information necessary to process my Insurance claims for services rendered to me by the office of Pioneer Valley Dermatology, PC. This assignment shall remain in effect until revoked by me in writing. I authorize payment of my Insurance to be made on behalf to Pioneer valley Dermatology, PC. I understand that I am financially responsible for all charges that are deemed not medically necessary by my Insurance, or other circumstances. I understand that it is my responsibility to obtain referrals for my visits, or I will be held liable for charges that result from that visit. I have read this information and understand its content.

_____ _____

Patient or Authorized Representative Signature **Date:**

_____

Patient or Authorized Representative Print Name