Pioneer Valley Dermatology, PC

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

NEW PATIENT INFORMATION SHEET

Name: ____

Address: ____

City: ____________________________________ State: ______________________ Zip: ________________

DOB: ___________________Marital Status: ______________________ SEX: M_________ F____________

Telephone: (Home) ______________________ (Work) ________________________ (Cell) ____________________

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

Social Security #: __________-______-__________

Email address: ____

Primary Care Provider: ____

What is your preferred pharmacy? ____

Person to contact in case of emergency: ____

Telephone #:____ Relationship: _____________________________

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.
ASSIGMNETS 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:**

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Patient or Authorized Representative Print Name