Pioneer Valley Dermatology
29B Cottage St. Amherst MA 01002
413-549-7400 Fax 413-549-7402
www.pioneervalleyderm.com

PATIENT INFORMATION SHEET

PATIENT NAME: ____
Last First MI Nickname

Marital Status ____________________ SS#____________________ DOB__________________________

Birth Sex ☐M ☐F Gender Identity ☐M ☐F ☐FTM ☐MTF ☐ Neither/Choose not to disclose

CONTACT INFORMATION

Your Home Phone #__________________________ Mobile Phone #__________________________________

Preferred Phone ☐ home ☐ mobile Is it OK to leave a message? ☐ Y ☐ N

Email ____Do you want to use our Patient Portal? ☐ Y ☐ N

Emergency Contact Full Name_________________________________ Phone #_______________________

LOCAL ADDRESS

Street Address ____

City____ State _______ Zip Code ________________

MAILING ADDRESS (if different)

Street Address ____

City____ State _______ Zip Code ________________

MEDICAL INFORMATION

Local Pharmacy ____________________________________ City ___________________________State_____

Primary Care Provider ____
Last Name First Name City State

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 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.

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Patient or Authorized Representative Signature Date:

The undersigned does hereby consent to medical treatment deemed advisable by Pioneer Valley Dermatology for the above listed minor child if child is under 18.

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Patient or Authorized Representative Print Name

Revised 5/6/2021