DiPreta Dermatology-Brunswick/Camden/Jesup/MS&SCC
2021 Patient Annual Intake Form for New & Established

Patient Full Name:_____ **Acct:** _____

Primary Mailing/Billing Address: _____

*City/State/Zip*_____

□ *Physical address (if different):*_____

Date of Birth:_____ Sex:____ Goes by/Nickname: _____

Marital Status: □ Single □ Married to _____ □ Divorced □ Other _____

Language(s): _____ Ethnicity: _____ Race: _____

Contact Phone Number(s): Home _____ Cell _____ Preferred Contact? Home Cell

ANY restrictions for contacting you? Y N Email Address: _____

Can we text reminders? Y N Email appointment reminders? Y N Email Statements? Y N

Emergency Contact Name: _____
Phone(s) # _____ Relationship: _____ * Please consider putting on HIPAA

Status: Student Retired Employed? Y N *If employed, Where*? _____

HOW DID YOU HEAR ABOUT US? ____ Family/Friend ____ Another patient ____ Phonebook ___ Internet
___ Billboard ____ Magazine Ad ____ Past Dr Swann ____ Healthfair ____ FLETC ___ Hosp ER
___ Past Dr Grooms/Perniciaro Pt ____ Referred by Dr _____ in _____

Primary Care Doctor/Provider: _____ in _____

Do you have insurance? __YES (***then must complete next section***) or __NO (*skip to bottom-self pay*)

INSURANCE: (you need to list name of plan and order plus we need copy of ins cards)

PRIMARY: _____ ID# _____ SS# _____
(*if not pt*) Insured Name:_____ Relationship: _____ Insured DOB: _____

SECONDARY:_____ ID# _____ SS# _____
(*if not pt*) Insured Name:_____ Relationship: _____ Insured DOB: _____

I have provided the most current address, contact phone numbers and insurance information along with current copies of all my insurance cards. I give permission for my insurance to be filed. I have reviewed and signed the HIPAA form and a financial policy. I am also aware that DiPreta Dermatology does not discriminate per Section 1557 and I can have access to interpretation services, if needed, at no additional fee.

My signature below signifies that I understand that I am responsible for updating this information at any future visits. If I fail to give correct or current info and can't be reached, it may delay communication of test results, appointment recalls or reminders and/or patient balance due after insurance processes charges.

SIGNATURE of PATIENT (guardian) _____

Relationship (if not pt): _____ Date: _____ **Pt Last Name:**_____