Arsenault DERMATOLOGY

Skin Care For Your Family

Required

Patient Information:

First	Middle	Last	Date of Birth	**Circle One:** Male/Female
Address		City,	State	Zip Code
Email Address			Primary Insurance Company	

Required

Contact Information:

MAY WE LEAVE DETAILED MESSAGES (i.e. Appointments, billing, results, etc.)?

Home #: ( ) -	Yes	No	N/A
Mobile #: ( ) -	Yes	No	N/A
Work #: ( ) -	Yes	No	N/A
Text Messages	Yes	No	N/A
May we discuss your care with anyone else?	Yes	No	

(if yes) First Middle Last Name | Relationship | Contact Tel. #

Required

Emergency Contact Information:

First Middle Last Name | Relationship | Contact Tel. #

Required

Privacy Acknowledgment:

_______ Initial **We are required to protect your privacy**
Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is available on our website and/or is furnished.

_______ Initial **We request all patients present photo ID at each visit, unless we have it on file.**
Your cooperation with HIPAA requirement is designed to protect your identity from misuse.

_______ Initial **Patients may revoke or change any provided authorizations at any time.**
Please refer to our NPP for more details.

Arsenault DERMATOLOGY

Skin Care For Your Family

Required

Which provider are you seeing today?

Circle One:	**Emily Arsenault, MD**	**Meredith Miller, PA-C**	**Kristin Jochum, PA-C**
Laura Marano, PA-C	**Melissa Beachy, PA-C**	**Conor Dolehide, MD**	**Christina M. Troiano, PA-C**

We are required to ask this of all patients.

You may choose not to specify.

Affordable Healthcare Act Questionnaire:

Race (check only one): ☐ **I choose not to specify**

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ White / Caucasian
- ☐ Native Hawaiian / Other Pacific Island
- ☐ Black / African American
- ☐ Other: ____________________

Ethnicity (check only one): ☐ **I choose not to specify**

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Preferred Language (check only one): ☐ **I choose not to specify**

- ☐ English ☐ Spanish
- ☐ American Sign Language
- ☐ Other: ____________________

Age 65 and over only please:

Do you have one of the following?

☐ Power of Attorney (Surrogate Decision Maker) ☐ Living Will (Advance Care Plan) ☐ None

Required

Pharmacy Name: ______________________________ Phone #: ______________

Address: ______________________________ Fax #: ______________

Primary Care Physician: ______________________________ Phone #: ______________

Address: ______________________________ Fax #: ______________

Month and Year of your last visit with your Primary Care Physician? ______________

Required

Payment

I hereby authorize my benefits, including Medicare, to be paid directly to Emily F. Arsenault, MD, PA and also authorize the release of medical information necessary to process claims. This assignment will remain in effect until revoked by me in writing. I understand that Emily F. Arsenault, MD, PA only files insurance claims for plans in which the practice participates. If I am not covered by one of the plans that the practice participates in, then payment is expected at the time of service. Applicable co-payments and deductibles for those insurance plans will be collected. If insurance does not pay, I will become financially responsible for payment in full.

______________________________ ______________

Signature of Patient or Responsible Party Date