BALDONE · REINA
DERMATOLOGY
THE SKIN HEALTH CENTER

Rhonda R. Baldone, M.D.
Board Certified Dermatologist

Rachel S. Reina, M.D.
Board Certified Dermatologist

PATIENT INFORMATION

Personal Information- Please print clearly Date____________

Last Name ______________________________ First Name ____________________________ M.I.____

Address ______________________________ City _________________________ State _____ Zip_______

Billing Address __________________________ City _______________________ State______ Zip_________

E-mail____________________________ Cell Phone _______________________Phone__________________

S.S.#______________________ Date of Birth ________________ Female ____ Male ____

Patient's marital status: Please Circle M S D W Other Student status: Full _____ Part _____

Person to contact in an emergency __________________________________Relationship___________

Primary Care Physician____Phone #_______________

Insurance Information - Please present insurance card to receptionist

Insured's name __________________________ Employer ___________________________________

Date of birth __________ Social Sec# __________________ Relationship to patient ______________

I chose Baldone Reina Dermatology based on which type of referral: **Please circle one**
Physician's – Family - Friend - Company - Yellow Pages - Newsletter - Newspaper Ad - Newspaper article- Hospital or Club Speech – Brochure

Whom may we thank for referring you? ____
Phone________________________ Alternate Phone____

1. I acknowledge full financial responsibility for services rendered and understand that payment of charges incurred is due at the time of service.
2. I authorize and request that insurance payments be made directly to Baldone Reina Dermatology should we elect to bill my insurance company and accept such payments.
3. I authorize Dr. Rhonda R. Baldone or Dr. Rachel Reina to evaluate and treat my medical condition.
4. I authorize the release of my Personal Health Information to the referring physician, to my insurance company, to laboratories, if applicable, for the purpose of treatment, payment, clinical management and administrative duties.
5. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and consent to insurance authorization and pre-certification for treatment.
6. I understand that it is my responsibility to notify this office of any changes in the above information.
7. I understand there will be a $15.00 service charge on any returned check.
8. I have been given the opportunity to review and/or receive a copy of this office's Notice of Privacy Practices.

Signed:____Date:__________________________

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www.baldonereinadermatology.com