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._____

Billing Address _____City _____ State _____ Zip _____

Preferred Phone# _(_____)_____ Alternate Number __(_____)_____

E-mail _____Would you like to receive emails for upcoming specials? ❑ Yes ❑ No

SS# _____ Date of Birth _____ ❑ Female ❑ Male

Preferred Language _____ Race_____ Patient's marital status: Circle M S W Other

Primary Care Physician (PCP) _____ PCP 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 check one

❑ Physician's ❑ Family ❑ Friend ❑ Company ❑ Yellow Pages ❑ Newsletter ❑ Newspaper Ad
❑ Newspaper Article ❑ Hospital or Club Speech ❑ Brochure ❑ Practice Website ❑ Internet

Whom may we thank for referring you? _____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:_____