



RICHMOND DERMATOLOGY & LASER SPECIALISTS
9816 Mayland Drive Richmond, VA 23233
804.282.8510 FAX 804.285.5750

PATIENT INFORMATION FORM

Previous Patient? Yes No New Patient Name Change Address Change Insurance Change

How did you hear about Richmond Dermatology: _____

Patient Name _____ Date _____

Gender: Male Female Age: _____ Patient's Date of Birth _____

Email Address _____

Please share your e-mail address if you would like to receive our newsletters and other important information.

Patient's Street Address: _____

City _____ State _____ Zip _____

Patient's Home Phone (____) _____ Work Phone (____) _____

Patient's Cell Phone (____) _____

Insurance Carrier _____ Referral Needed? Yes No

Secondary Insurance Carrier: _____

Policy Holder's Last Name _____ First _____

Policy Holder's Date of Birth _____ Gender: Male Female

Referring Physician's Last Name _____ First _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature

Date

Please provide your insurance card(s) and driver's license
to the receptionist along with this form