FRYER DERMATOLOGY, PLLC

210-08 Northern Blvd; Ste 2
Bayside, NY 11361

150 Broadhollow Road; Ste 100
Melville, NY 11747

PLEASE COMPLETE *ALL* INFORMATION BELOW – PLEASE PRINT CLEARLY

FIRST NAME________________________________MI__________LAST NAME____

STREET ADDRESS____CITY__________________________________

STATE_______________ZIP______________ HOME PHONE________-__________-_____________

CELL PHONE__________-_________-_____________ WORK PHONE_________-_________-_______________

E-Mail____ Preferred Contact: Cell Home Work

Date of Birth_________________________ Age______ Gender: M F Marital Status: S M D

SOC SEC NO:_____________-________-_____________ School (if student):___________________________

Race: White African American Native American Asian Hispanic Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino Primary Language___________________

Employer________________________________ Primary Care Physician______________________________

Occupation______________________________ Referred by____________________________________

PHARMACY: IMPORTANT: WE ARE LEGALLY REQUIRED TO E-PRESCRIBE

NAME______________________________STREET/TOWN________________________________TEL___________________________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:____

NAME____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER

STREET____ CITY____________________________STATE/ZIP__________________

DATE OF BIRTH______________________________ SOC SEC NO________-________-___________ GENDER: M F

INSURED ID#__________________________________ GROUP #______________________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY:____

NAME____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER

STREET____ CITY____________________________STATE/ZIP__________________

DATE OF BIRTH______________________________ SOC SEC NO________-________-___________ GENDER: M F

INSURED ID#__________________________________ GROUP #______________________________________

Authorization to Pay Benefits to Physician: I hereby authorize Fryer Dermatology, PLLC to release any medical information regarding medical history, services or treatments rendered to me or my dependent for purposes of insurance claims and authorize the assignment of benefits directly to Fryer Dermatology, PLLC. I accept financial responsibility for services not paid by insurance including all deductibles/copayments/coinsurance, non-covered services, lack of necessary referrals and any fees not paid by my insurance (for any reason) within 120 days of the date of service. I understand that all copays are due on the day of my visit and failure of payment at that time will result in an additional fee. There will be a $25.00 fee for appointments missed without being cancelled within 24 hours.

Patient or Authorized signature:____Date: __________________________