Appointment Date: _____

Time: _____

Account #: _____

DAKOTA DERMATOLOGY

4950 South Minnesota Avenue
Sioux Falls, South Dakota 57108
Phone: (605) 330-9619 • Fax: (605) 330-9503
Toll Free: (888) 986-6022

- ❑ James R. McGrann, M.D.
- ❑ Sarah K. Sarbacker, M.D.
- ❑ Kelly M. Jerstad, M.D.
- ❑ Carmen M. Schwartz, M.D.
- ❑ Cheryle L. Brandt, PA-C
- ❑ Kathrine A. Jibben, PA-C
- ❑ Rachel Rydell, PA-C

Please present your insurance card(s) to receptionist along with this completed form.

RESPONSIBLE PARTY INFORMATION

Name: _____
(Person responsible if patient is a minor.)

Address: _____ Phone: _____
(Street or Route) (City) (State) (Zip)

PATIENT INFORMATION

Mr. Mrs. Ms. Minor Child Other

PATIENT: _____
(Last) (First) (M.I.)

Address: _____
(Street or Route) (City) (State) (Zip)

Home Phone:_____ *Cell Phone:_____ Work Phone:_____

As a service to our clients, we provide a courtesy appointment reminder call using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

MAY WE LEAVE A DETAILED VOICEMAIL MESSAGE? Yes No

WOULD YOU PREFER TO RECEIVE YOUR APPOINTMENT REMINDER BY PHONE CALL OR TEXT MESSAGING?

Phone: #_____ Text: #_____

Email Address: _____

By providing your email address, you consent to receiving email messages regarding your portal account.

Date of Birth: _____Age:_____Sex: _____Social Security No.: _____

PREFERRED LANGUAGE: English Spanish Other_____

RACE: White Black/African American Asian Hispanic Declined Other_____

ETHNIC GROUP: Hispanic or Latino Not Hispanic or Latino Declined

EMPLOYER: _____Business Phone: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Occupation:: _____

EMERGENCY CONTACT: _____
(Last) (First) (M.I.)

Relationship:_____ Phone:_____

Employer: _____

Business Address: _____Business Phone: _____

REFERRAL INFORMATION

Name: _____

Address: _____

Doctor Friend/Relative Employer Telephone Book Internet Other

PLEASE NOTE: All professional services rendered are charged to the patient or responsible party. Necessary forms will be sent directly to the patient to expedite insurance payments. The patient or responsible party is responsible for payment of all fees, regardless of insurance coverage.

RESPONSIBLE PARTY INFORMATION

REQUIRED INFORMATION

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY #1:

_____

_____

Name of Policyholder: _____

Policyholder DOB: _____

What is Patient's Relationship to Policyholder: _____

Policyholder ID#: _____

Policy Group#: _____

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY #2:

_____

_____

Name of Policyholder: _____

Policyholder DOB: _____

What is Patient's Relationship to Policyholder: _____

Policyholder ID#: _____

Policy Group#: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize DAKOTA DERMATOLOGY to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physician(s), all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

X _____ _____
(Signature) (Date)

REGULATION Z — CONSUMER PROTECTION ACT

The following disclosures, in connection with your account, are made pursuant to the Federal Truth-In-Lending Act.
A FINANCE CHARGE is computed on account balances unpaid 90 days after the first billing at PERIODIC RATE of 1 1/2% PER MONTH; ANNUAL PERCENTAGE RATE IS 18%.

You may pay your total unpaid balance at any time.

Please feel free to come in and discuss these terms with us if additional information is desired.

I have read the disclosure form, as required by the "Truth-In-Lending" Act, and hereby agree to its terms and conditions; and acknowledge receipt of the disclosure form.

X_____
(Signature of Patient or Responsible Party)

_____
Office Manager
DAKOTA DERMATOLOGY

Is there any family member that you would like us to share your health information?

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

X _____ Date _____
(Signature of Patient or Responsible Party)