

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

Appointment Date: _____

Time: _____

Account #: _____

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

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY #1:

INSURANCE COMPANY #2:

★ Name of Policyholder: _____

★ Name of Policyholder: _____

★ Policyholder DOB: _____

★ Policyholder DOB: _____

What is Patient's Relationship to Policyholder: _____

What is Patient's Relationship to Policyholder: _____

★ Policyholder ID#: _____

★ Policyholder ID#: _____

Policy Group#: _____

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)

Our business office will submit claims for covered services and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all current and necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim as soon as the primary carrier has paid. Your insurance company may require you to supply certain information directly, it is your responsibility to comply with their request.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full may be required until we can verify your coverage.

******If you would like to discuss fees for medical services, please see our billing office.******

Do you have an Advanced Directive? Yes No

Who is your Surrogate/Director? _____

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

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

X _____
(Signature of Patient or Responsible Party)

Date _____