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

❏ SARAH K. SARBACKER, M.D.
❏ KELLY M. JERSTAD, M.D.
❏ CARMEN M. SCHWARTZ, M.D.
❏ KENDRA D. WATSON, 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: ___________________ DOB: ___________________
(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) (Legal First) (Nickname) (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 ❏ Website ❏ Facebook ❏ 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)

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? ________________________________

I hereby authorize the following individuals involved in my care to communicate with Dakota Dermatology regarding my medical and/ or billing information.

Name: ____________________________ Relationship to Patient: ________________

Name: ____________________________ Relationship to Patient: ________________

X ________________________________ Date ____________________
(Signature of Patient or Responsible Party)