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 R. Hotvet, PA-C
- ❑ Stephanie J. Stelton, PA-C
- ❑ Heidi M. Furth, CNP

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

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Minor Child ☐ Other

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

Date of Birth: _____ Age: _____ Sex: _____ **Social Security No.**: _____

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.

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: _____

RESPONSIBLE PARTY INFORMATION

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

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

Patient's Relationship to Responsible Party: _____

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.

CONTINUED ➔

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 will submit your claim to but do not have your insurance card with you upon check-in, payment in full may be required until you are able to supply us with the necessary information to file your claim.

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

COMMUNICATION AUTHORIZATION

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)