DAKOTA DERMATOLOGY

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

Appointment Date: ____________________

Time: ________________________________

Account #: ___________________________

- ❑ 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

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 ____________________________________ (Signature of Patient or Responsible Party)

Date ____________________