Chadds Ford Dermatology
6 Dickinson Drive 300 Building Suite 311
Chadds Ford, Pa. 19317
Phone 610-558-1200 Fax 610-558-7325
Dr. Allison Britt Kimmins, M.D., M.P.H. Christa Cavanaugh, PA-C

Date: _____

Name: _____ Date of Birth: _____

Street Address: _____ City / State: _____

Zip Code: _____ Gender: _____ Social Security # _____

Marital Status : _____ **Occupation :** _____

Phone Number (Primary): _____

okay to leave message with detailed information on voicemail or with anyone who answers : Y or N

Phone Number (cell): _____

okay to leave message with detailed information on voicemail or with anyone who answers : Y or N

Email Address: _____

Emergency Contact: _____ Phone # _____

With whom, if anyone can we discuss your medical record? _____

Relationship : _____

Guarantor if different from patient: _____

Insurance:

Please present your cards to be scanned into your chart – Please fill in additional information if different from patient:

Primary Insurance Name: _____

Primary Policy Holder's Name: _____ & DOB _____

Secondary Insurance Name: _____

Policy Holder's Name: _____ & DOB _____

Primary Care Physician

Name: _____ Phone Number: _____ City or Zip Code: _____

Preferred Pharmacy

Name: _____ Phone Number: _____ City or Zip Code:_____

Please complete both sides

Over

Allergies

List all allergies and reactions if known:

_____
_____
_____

Medications

-- Please present a list for copying if not please list all current medications, including all Vitamins, Supplements & Over the counter meds -

Please include dosage and quantity:

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Do you have an Advance Health Directive (Living Will)? Y or N

If yes, who is in charge of your medical care / surrogate decision maker? _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

_____ _____

Patient or Responsible Party Signature Date