

## We Welcome You...

...and thank you for selecting us for your healthcare needs. We are dedicated to providing you with the best possible healthcare. To help us, please fill out this form *completely* in ink. If you have any questions, please ask us - we will be happy to assist you.

### 1. Personal Information

Today's Date \_\_\_\_\_

Patients' name ( Mr / Mrs / Ms /Dr) \_\_\_\_\_

Patient *Street* Address \_\_\_\_\_

City/ State/ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_ Female\_\_\_ **Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Minor \_\_\_; Single \_\_\_; Married \_\_\_; Divorced \_\_\_; Separated \_\_\_; Widowed \_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### 2. Telephone Information

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

**In the event of an emergency, who should we contact?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### 3. Responsible Party (If not Patient)

Who is responsible for the account? \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of birth \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

### 4. Insurance Information

#### *Primary Insurance*

Name of Insured \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insured's Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Employee I.D./Cert.# \_\_\_\_\_

Group # \_\_\_\_\_

#### *Secondary Insurance*

Name of Insured \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insured's Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Employee I.D./Cert.# \_\_\_\_\_

Group # \_\_\_\_\_

5. Financial Arrangements

Please remember, PAYMENT IS DUE IN FULL AT TIME OF VISIT. For your convenience, we offer the following methods of payment;

*(Please check which you prefer)* Cash \_\_\_\_\_ Personal Check \_\_\_\_\_

Credit Card: MC\_\_\_\_ VISA \_\_\_\_\_ American Express \_\_\_\_\_

6. Authorization and Release *(please sign below)*

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

***Medicare Patients:***

I request the payment of authorized benefits be made to the Dermatology Clinic, PLLC on my behalf for any services furnished to me by her.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X \_\_\_\_\_

**Signature of patient (or parent if minor)**

**Date**