

Today's date _____

WELCOME

For office use only.

1 Patient Personal Information

Name: _____ Jr./Sr. _____

Prefer to be called: _____ Title: _ Mr. _ Mrs. _ Ms. _ Miss _ Dr.

Age: _____ Date of Birth: _____ Social Security #: _____

_ Male _ Female _ Student If student, name of school: _____

Address: _____

City, State, Zip Code: _____

Driver's License #: _____ Employer/Occupation _____

Spouse: _____ Employer/Occupation _____

Who referred you? _____ _ Physician _ Friend _ Relative _ Self

Who is your regular doctor? _____

Where should statements of your account be sent if different from above? Name _____

Address _____

2 Telephone

Home Phone: _____ Work Phone _____ Ext: _____

I prefer to receive calls at: _ Home O Work Best time of day to reach me: Time: _____ Day/s: _____

I give my permission to: _ Leave a message on my answering machine at home.

_ Leave a message at my place of employment.

_ Discuss my medical condition, lab results or financial information to the following person/s

Name/s and Relationship _____ Phone #: _____

In case of EMERGENCY, please give name of nearest friend or relative you wish to have contacted.

Name _____ Phone #: _____

Pharmacy where I get my prescriptions: _____ City: _____

3 Responsible/Insured Party

If policy owner is other than the patient, please provide the following information:

Name _____ Patient/Policy owner relationship? _ Self _ Child _ Spouse _ Other

Birthdate: _____ Driver's License #: _____ Social Security #: _____

Address: _____

City, State, Zip: _____

Employer: _____ If unemployed, check here. _

Work Phone: _____ Home Phone: _____

Please complete reverse side and sign!

4 Health Insurance Information

Please complete the following information for proper and timely claim submission.

PRIMARY INSURANCE

ADDITIONAL INSURANCE

Insurance Company _____ Insurance Company _____

Ins. Co. Address _____ Ins. Co. Address _____

Name of Insured _____ Name of Insured _____

Group # _____ Group # _____

Employee/Certificate # _____ Employee/Certificate #: _____

Please photocopy front and back of insurance card and mail back to our office with paperwork.

Thank you!

5 Payment Policy

Please read carefully!

We accept VISA, MASTERCARD, and DISCOVER

1. To keep overhead costs at a minimum, we request PAYMENT AT TIME OF SERVICE. Payment of your part of the charges includes co-payments and deductibles for your insurance company.
2. If payment causes a real difficulty for you, please contact the office manager regarding a limited payment plan.
3. An adult bringing their child in for an appointment is responsible for payment.
4. For your convenience, there are several payment options. Please choose the payment option you prefer from the following:

CASH PERSONAL CHECK CREDIT CARD

6 Authorization, Release & Confidentiality

My signature below authorizes any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or any carrier, any information needed for this or a related Medicare or other insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Further, my signature indicates that I understand and accept the financial policy described above. All therapeutic communications, records, and contacts with the Dermatology, Skin Cancer & Laser Center staff will be held in strict confidence in accordance with the Health Insurance Portability & Accountability Act (HIPAA). I can request my medical records in writing via mail or FAX. If I have any questions, your staff is trained to assist me.

◆◆◆◆◆◆◆◆ Signature of patient or legal guardian ◆◆◆◆◆◆◆◆◆◆

_____ Date

Did you remember to sign this form!