PATIENT INFORMATION ***(Please Print)*** Today's Date: _____/_____/_____

Name _____
Last *First* *M.I.*

Mailing Address _____

City _____ State _____ Zip _____

E-mail Address _____ SS# _____

Home Phone _____ Work Phone _____ Cell _____
Area Code *Area Code* *Area Code*

Date of Birth _____/_____/_____ Age _____ Gender _____ Marital Status _____

PARENT OR RESPONSIBLE PARTY ***(if different from patient)***

Name _____
Last *First* *M.I.*

Mailing Address _____
City *State* *Zip*

Home Phone _____ Work Phone _____ Cell _____
Area Code *Area Code* *Area Code*

INSURANCE INFORMATION ***(Only complete if card not presented at time of check in)***

PRIMARY (Insurance Name) _____
Name of Insured _____
Insured's ID# _____
Group # _____ Effective date _____
Relationship of patient to the Insured _____

SECONDARY (Insurance Name) _____
Name of Insured _____
Insured's ID# _____
Group # _____ Effective date _____
Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of Choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I consent to all skin examinations necessary for the treatment of the condition about which I have consulted this office. I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party signature _____ Date _____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay the unmet deductible, non-covered services and co-payments. There is a $25.00 fee for any returned checks. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party signature _____ Date _____/_____/_____

For office use only: Photo ID witnessed by_____Date_____/_____/_____