

PLEASE PRINT

PATIENT INFORMATION

DR.MR.MRS.MS. FIRST NAME: _____ MI: _____ LAST NAME: _____
ADDRESS: _____ APT: _____ BIRTHDATE: _____
CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____
HOME PH: _____ CELL PH: _____ SS#: _____ AGE _____
MARITAL STATUS: SINGLE MARRIED LIFE PARTNER DIVORCED WIDOWED CHILD SEX: M F
EMPLOYER: _____ WORK PH: _____
SPOUSE'S NAME: _____ SPOUSE'S WORK PH: _____
PCP: _____ REFERRING MD: _____

GUARANTOR/ RESPONSIBLE PARTY

NAME: _____ RELATIONSHIP TO PT: _____
ADDRESS: _____ APT: _____ BIRTHDATE: _____
CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____
HOME PH: _____ CELL PH: _____ SS#: _____ SEX: M F
EMPLOYER: _____ WORK PH: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: TO PT: _____
ADDRESS: _____ HOME PH: _____ CELL PH: _____

INSURANCE INFORMATION

NAME OF **PRIMARY INSURANCE**: _____
POLICY HOLDER: _____ SS#: _____ BIRTHDATE: _____
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER _____
NAME OF **SECONDARY INSURANCE**: _____
POLICY HOLDER: _____ SS#: _____ BIRTHDATE: _____
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER _____

A copy of your insurance card(s), front & back
will be affixed here. It must be up to date.
If we cannot confirm that your policy is in effect,
you will be asked to reschedule your appointment.

I hereby authorize the release of pertinent information to insurance carriers & authorize my insurance benefits to be paid directly to DermAssociates PC. Covered medical services which I receive today will be submitted to my insurance company based on the information I have provided. Services considered non-covered or cosmetic in nature will be my responsibility and paid at the time of service. Outstanding patient balances not paid within 60 days of first billing will be sent to an outside agency for collection. Your insurance is a contract between you and your employer or you and your insurance company. We are not a party to that contract. Different policies cover different services, furthermore, some insurance companies select those arbitrarily. Therefore, it is incumbent upon each patient to familiarize himself with his policy. Returned checks are subject to a \$25 fee in addition to the original check amount. Missed appointments also incur a \$25 fee.

***We must emphasize that as medical care providers, our relationship is with you, not your insurance company.
All charges are your responsibility from the date services are rendered.***

Patient/Responsible Party Signature: _____ Date: _____