Patient Account #__________________

PATIENT INFORMATION (Please Print Legibly) Today's Date___/____/____

Name: ____
Last First Middle

Date of Birth ___/____/____ Age: ______ Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W

Mailing Address: ____
P.O. Box or Street Name

____
City State Zip Code

Home Phone: ___________________________________Work Phone: __________________________________

Cell Phone: _____________________________Email Address: ____

Primary Care Physician: ____
Name of Physician Phone Number

Referred by: ☐Primary Care Physician ☐ Family/Friend ☐Website ☐ Other: ____________________

Insurance Information (Please present insurance card(s) at time of check in.)

Subscriber of Plan: ____
Name (Person who holds insurance) Date of Birth Relationship to Patient

Where should statements of your account be sent if responsible party is different than above?

Name: ____

Relationship to Patient: _________________________________ Phone # ______________________________

Address: ____
P.O. Box or Street Name City State Zip Code

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

____ ________________
Signature of parent of legal guardian Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS

I request that payment of authorized medical benefits be made to me or on my behalf to Adult & Pediatric Dermatology, p.c. for services furnished me, including physicians services. I authorize any holder of medical information about me to release to my insurance carrier or its intermediaries any information needed for its or a related claim. Claims rejected by the insurer are the financial responsibility of the patient. I received and understand the statement of office financial policies and notice of privacy practices.

SIGNED____ DATE: ______________________

☐ Financial Policy ☐ Notice of Privacy Practices (please check boxes after reading the policies)