

PLEASE PRINT

PATIENT INFORMATION

Mr	Mrs	Dr	Ms	First Name	MI	Last Name				
Address						Apt/Unit #	Birthday / /			
City			State	Zip Code		E-Mail				
Home Phone		Cell Phone		Work Phone		Social Security #			Age	
Marital Status (circle one)	Single	Married	Life Partner	Divorced	Widowed	Child	Sex		M	F
Employer				Spouse/Partner's Name			Spouse/Partner's work number			
Primary Care Physician				Referring Physician						

GUARANTOR / RESPONSIBLE PARTY

Name						Relationship to Patient				
Address						Apt/Unit #	Birthday / /			
City			State	Zip Code		Email				
Home Phone		Cell Phone		Social Security Number			Sex		M	F
Employer				Work Phone						

EMERGENCY CONTACT

Name						Relationship to Patient				
Address						Home Phone		Cell Phone		

INSURANCE INFORMATION

Name of PRIMARY Insurance										
Policy Holder						Social Security #		Birthdate of Policy Holder		
Relationship to Patient (circle one)		Self	Spouse	Parent	Other:					
Name of SECONDARY Insurance										
Policy Holder						Social Security #		Birthdate of Policy Holder		
Relationship to Patient (circle one)		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 \$35 fee in addition to the original check amount. Missed appointments also incur a \$50 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 Signat						Date				
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