

# Welcome to the Dermatology Center

PLEASE PRINT CLEARLY

Patient's Full Name \_\_\_\_\_  
Last First Middle Initial

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_ @ \_\_\_\_\_ For Free Skincare Newsletter

Title:  Mr.  Mrs.  Miss  Ms  Other \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  Married  Single  Widowed

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender  M  F

Employed By \_\_\_\_\_ Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred by  Dr. \_\_\_\_\_ City \_\_\_\_\_  Family  Friend  Phone Book  Insurance

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

---

Responsible Party (**Primary Insured Person**) \_\_\_\_\_  
Last First Middle Initial

Relationship to Patient:  Self  Parent  Spouse  Other \_\_\_\_\_

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Title:  Mr.  Mrs.  Miss  Ms  Other \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Gender  M  F

Employed By \_\_\_\_\_ Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to the attending physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assigned to release all information necessary to secure payment. I authorize the release of medical information to my referring physician to ensure continuity of care.

SIGNED \_\_\_\_\_ Date \_\_\_\_\_

I CERTIFY that all the above information is current and correct. I understand that failure to give correct information on my HMO or PPO insurance before my visit may result in my being responsible for all charges incurred. PAYMENT for professional services is the patient's individual responsibility at the time services are rendered. This includes all deductibles, co-insurance and co-payments.

SIGNED \_\_\_\_\_ Date \_\_\_\_\_

Type of Insurance:  PPO  HMO  Medicare  Private Pay