

PATIENT INFORMATION

Patient Name _____ Date of Birth: _____
(Please Print) First Middle Int. Last Month/Day/Year

Address: _____
Street (Apt.#) City State Zip Code

Phone: _____ Work Phone: _____

Patients Social Security Number: _____

Patients Employer: _____ Occupation: _____

Do you feel that your condition is work related? Yes [] No []

Referring Dr. _____ Clinic _____

Marital Status: Married [] Spouse's Name: _____

Spouse's Employer: _____

Single [] Divorced [] Widowed [] Separated []

Bill To: Name: _____ Relationship: _____

If patient is covered under parental insurance policy please complete information for both parents.

Fathers Name: _____ Phone: _____

Address: _____
Street (Apt.#) City State Zip Code

Employer: _____ Occupation: _____

Mothers Name: _____ Phone: _____

Address: _____
Street (Apt.#) City State Zip Code

Employer: _____ Occupation: _____

If minor, patient lives with: Mother [] Father [] Both Parents []

Is patient covered under Medicare? Yes [] No []

If yes, Medicare # _____

Is patient covered by any other policy that isn't a Medicare supplement policy, including spouse? Yes [] No []

Primary Insurance: _____ Secondary Insurance: _____

Employer: _____ Employer: _____

Social Security #: _____ Social Security #: _____

Policyholder Name: _____ Policyholder Name: _____

Policyholder Birthdate: _____ Policyholder Birthdate: _____

Relationship to Pt.: _____ Relationship to Pt.: _____

Patient is responsible for any dollar amount not paid by insurance.

I AUTHORIZE INSURANCE PAYMENT DIRECTLY TO: Dermatology Clinic S.C.

Date: _____ X _____
Signature

Account Number: _____