***PATIENT INFORMATION****:* *Please write clearly.* Todays Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name you are called by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (physical) STREET:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_

Address (billing) STREET\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_

Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Responsible party (if not patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SOCIAL HISTORY:***

**Sex**: □Male □Female **Ethnicity**: □Hispanic/Latino □Not Hispanic/Latino Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language spoken at home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: □Single □Married □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employers Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PRIVACY:*** □YES □NO The Dermatology Center may leave messages on my answering machine or with a family member.

□YES □NO The Dermatology Center may release information to my spouse or family.

***INSURANCE INFORMATION:***

***Primary Insurance****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***\*\*Policy Holders Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*Policy Holders Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to policy holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Secondary Insurance****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***\*\*Policy Holders Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*Policy Holders Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to policy holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize payment of insurance benefits, otherwise payable to me, directly to The Dermatology Center. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents. I authorize the Dermatology Center to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that payment in full for all charges is not made, I agree to pay for all costs of collection including a collection fee and court costs.

**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of patient or guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_

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**MEDICARE PATIENTS ONLY:**

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and to request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of patient or guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**