DERMATOLOGY AND DERMATOLOGIC SURGERY CENTER, P.C.

Patient Name____ Nickname ____________________
Last First Middle

Home Address____ Apt # ______________________
(Please use street address and P.O. Box if needed)

City ______________________________ State ______________________ Zip Code ______________

Home Phone # __________________________ Sex – Male / Female Marital Status M S D W

Date of Birth __________________________ SS # __________________________________

Referring Doctor Information ____
(Name, Address, and Phone Number)

Patient Employer ____________________________________ Work Phone# ________________________

Nearest Relative Not Living With You __________________________ Phone # ______________________

Insurance Information

Person financially responsible for this bill? ______________________________ Relationship? ______________

Their Address? (if different from patient) ____
Street City State Zip

Their SS# _________________ Employer ___________________________ Work Ph# ______________

Primary Insurance Name _____________________________ Policy Holder _________________________

Insurance Address _________________________________ Policy/Group Number _____________________

Policy Holder's Employer ____________________________ Policy Holder's Date of Birth _________________

Policy Holder's Address (If different from patient) ____
Street City State Zip

Secondary Insurance Name ___________________________ Policy Holder__________________________

Insurance Address _________________________________ Policy/Group Number _____________________

Policy Holder's Employer ____________________________ Policy Holder's Date of Birth _________________

Policy Holder's Address (If different from patient) ____
Street City State Zip

Authorization to Release and Assign Insurance Benefits

I authorize release of my information to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to the above the medical and/or surgical benefits. I am entitled for the above listed services from my insurance company. This is to serve as a lifetime authorization. This authorization also applies to the treatment, payment and healthcare operations, as outlined in HIPAA regulations, and also for the RELEASE OF MEDICAL RECORDS to any physician whom I may be referred to by the Dermatology and Dermatologic Surgery Center, P.C.
I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered. I certify the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature ____ Date ____________________

Parent Signature (if minor) ____ Date ____________________