

**PATIENT INFORMATION**

DATE	AGE	BIRTH DATE
PATIENT NAME	FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>	
ADDRESS	PHONE	CELL PHONE
CITY/STATE	SOCIAL SECURITY #	
ZIP CODE		
SPOUSE/PARENT	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	

PATIENTS EMPLOYER	OCCUPATION	PHONE
SPOUSE'S/PARENT'S EMPLOYER	OCCUPATION	PHONE
FRIEND OR RELATIVE (LOCAL)	RELATIONSHIP	
ADDRESS	PHONE	
REFERRED BY	FAMILY DOCTOR	PHONE

INSURANCE COVERAGE # 1 (PRIMARY)  
COMPANY NAME

SUBSCRIBER NAME	BIRTH DATE	
I.D. #	GROUP #	REFERRALS NEEDED? YES <input type="checkbox"/> NO <input type="checkbox"/> COPAY? YES <input type="checkbox"/> NO <input type="checkbox"/> AMOUNT\$
INSURANCE ADDRESS	CITY/STATE	ZIP CODE
INSURED THROUGH: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/>		

INSURANCE COVERAGE # 2 (SECONDARY)  
COMPANY NAME

SUBSCRIBER NAME	BIRTH DATE	
I.D. #	GROUP #	REFERRALS NEEDED? YES <input type="checkbox"/> NO <input type="checkbox"/> COPAY? YES <input type="checkbox"/> NO <input type="checkbox"/> AMOUNT\$
INSURANCE ADDRESS	CITY/STATE	ZIP CODE
INSURED THROUGH: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/>		

I hereby authorize the release of all medical information necessary to process claims. I hereby authorize my insurance company to make payments directly to Dermatology Associates P.C. I am personally responsible for any balance due on my account. If my insurance company requires a referral for this or future visits, and one is not obtained, I will be responsible for any charges incurred. I guarantee payment for all charges, whether or not paid by insurance.

SIGNED	DATE
PRIVACY NOTICE GIVEN DATE:	