MEDICAL CENTER DERMATOLOGY PATIENT INFORMATION

Today's Date: ___/___/___

Name: _____ Nickname: _____

Last *First* *M.I.*

Date of Birth: ___/___/___ Age: _____ Social Security #: _____ Male / Female

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

ADDRESS _____

City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Email: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (*if different from patient*)

Name: _____ Relationship: _____

INSURANCE COVERAGE – PRIMARY

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____ Employer: _____

Policy Holder (Insured) Date of Birth: ___/___/___ Social Security #: _____

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____ Employer: _____

Policy Holder (Insured) Date of Birth: ___/___/___ Social Security #: _____

Referred by: _____

Other family members that are patients: _____

May we leave personal medical information on your: Please check: ___ Answering machine at Home, ___ Cell Phone, ___ Voicemail at Work

Do you give our office permission to discuss your medical information with other people?

☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Daytime Phone: ( ) _____ Evening Phone: ( ) _____

Do you give our office permission to discuss protected health information with you via email? ☐ YES ☐ NO

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone Numbers:

Home( )_____ Work: ( )_____ Cell: ( )_____

INSURANCE CARD

To be able to file with your insurance company, we must have your current insurance card on the day you are seen. We are not able to file without an insurance card. If you do not have your card, payment will be required at the time of service, and we will give you an itemized receipt so you can file the claim yourself. If the card that you present is not current or does not contain correct information, you will be responsible for the charges. We will not be able to refile the claim again later. Thank you. **Initials:** _____

MISSED APPOINTMENT

There will be a $25 charge for appointments that are cancelled with less than 24 hours notice. The charge will be $75 for surgical or other longer appointments. This will help us to have more appointments available for other patients. You are welcome to leave a message on our answering machine if you are not able to call during regular office hours. Thank you. **Initials:** _____

COSMETIC CONSULTATIONS AND PROCEDURES

Cosmetic consultations and cosmetic procedures are not covered by insurance. You will be responsible for payment at the time of service. Thank you. **Initials:** _____