SKIN CANCER & DERMATOLOGY CENTER

PLEASE GIVE ALL INSURANCE CARDS & DRIVER'S LICENSE TO THE PATIENT SERVICE REPRESENTATIVE.
PLEASE PRINT AND FILL OUT THE FORM COMPLETELY.

PATIENT INFORMATION

Patient's Last Name:	First:	M. I.	Sex: ❑ M ❑ F	❑ Mr. ❑ Mrs. ❑ Dr ❑ Ms. ❑ Miss

Street Address:	City:	State:	ZIP Code:

Home Phone No.:	Employer Phone No.:	Cell Phone No.:
( )	( )	( )

Preferred Phone No.: (circle one)	Marital Status: (circle one)	Date of Birth:	Social Security No.:
Home / Work / Cell / Other: _____	Single / Married / Divorced Separated / Widowed / Other	/ /	

Email Address:	Employer:

INSURANCE INFORMATION

PRIMARY INSURANCE	SUBSCRIBER'S NAME (If different than above)	Group No.:	Policy No.:

Copayment:	Relationship to patient: (circle one)	Address of Subscriber: (If different than above)	Sex: ❑ M ❑ F	Home / Cell / Work No.: (circle one)
$	Self / Spouse / Parent / Other			( )

Subscriber's Date of Birth:	Subscriber's Social Security No: (If different than above)	Employer: (If different than above)
/ /		

SECONDARY INSURANCE	SUBSCRIBER'S NAME (If different than above)	Group No.:	Policy No.:

Copayment:	Relationship to patient: (circle one)	Address of Subscriber: (If different than above)	Sex: ❑ M ❑ F	Home / Cell / Work No.: (circle one)
$	Self / Spouse / Parent / Other			( )

Subscriber's Date of Birth:	Subscriber's Social Security No.: (If different than above)	Employer: (If different than above)
/ /		

TERTIARY INSURANCE	SUBSCRIBER'S NAME (If different than above)	Group No.:	Policy No.:

Copayment:	Relationship to patient: (circle one)	Subscriber's Social Security No.: (If different than above)	Sex: ❑ M ❑ F	Subscriber's Date of Birth:
$	Self / Spouse / Parent / Other			/ /

REFERRING AND RESPONSIBLE PARTY INFORMATION

Referred By: (please check appropriate box)

❑ **Friend/Relative** ❑ **Google** ❑ **Healthgrades** ❑ **Internet Ad** ❑ **Other:** _____ ❑ **Referring Provider:** _____

PCP Name (If different than your referring provider):_____

Legally the responsible party is the person signing the financial agreement and/or the patient. Regarding patients up to the age of 26: We are aware there are reasons patients wish to have financial statements sent to an additional person(s). If you want the statement sent to someone other than the patient/responsible party, please list the name, address, DOB, and relationship to the patient below. The practice reserves the right to default to the primary subscriber.

Name: _____ Relationship to the patient: _____ DOB: _____

Address: _____ Phone Number: _____

IN CASE OF EMERGENCY AND ACKNOWLEDGMENT

Name of Spouse/Relative/Friend:	Relationship to patient:	Home / Cell / Work No.: (circle one)
		( )

By signing below, I authorize treatment from Skin Cancer & Dermatology Center. I authorize my insurance benefits to be paid directly to the provider/practice. I understand that I am financially responsible for any balance. I also authorize Skin Cancer & Dermatology Center or my insurance company to release any information required to process my claims. Authorization approved for minimal twelve months from date of my signature. The above information is accurate to the best of my knowledge.

Patient/Guardian Signature:	***Printed Name:***	***Date:***