

Date _____

Patient Account # _____

COMPLETE FAMILY DERMATOLOGY PATIENT INFORMATION

PATIENT INFORMATION~PLEASE FILL IN ALL INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SEX: M / F MARITAL STATUS: S M D W SEP BIRTH DATE _____ SS# ____/____/____

ETHNICITY _____ RACE _____ LANGUAGE _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

PRIVATE PAY (PT RESP) __YES __NO EMAIL ADDRESS: _____

STUDENT / RETIRED EMPLOYER _____ PART TIME / FULL TIME

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRING PHYSICIAN (first and last name) _____

PRIMARY PHYSICIAN (first and last name) _____

SUBSCRIBER INFORMATION-MUST BE COMPLETED TO FILE INSURANCE

SUBSCRIBER LAST NAME _____ FIRST _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SEX: M / F MARITAL STATUS: S M D W SEP BIRTH DATE _____ SS# ____/____/____

SUBSCRIBER RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / CHILD / OTHER

EMPLOYER _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT OR RESPONSIBLE PARTY (IF UNDER THE AGE OF 19 YEARS OF AGE)

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SEX: M / F MARITAL STATUS: S M D W SEP BIRTH DATE _____ SS# ____/____/____

RELATIONSHIP TO PATIENT: PARENT / RELATIVE / OTHER EMAIL _____

EMPLOYER _____ ADDRESS _____ CITY _____ ST _____ ZIP _____

COMPLETE FAMILY DERMATOLOGY

Patient Name _____

Patient Account # _____

MEDICAL RELEASE

I authorize Complete Family Dermatology to release information concerning any and all diagnostic studies and findings contained within my clinic files (whether performed here or elsewhere) to the family member or parties listed below:

NAME _____ RELATIONSHIP _____ PHONE _____

EMERGENCY CONTACT

EMERGENCY CONTACT _____ PHONE _____ Cell _____

ADDRESS _____ DATE OF BIRTH _____

RELATIONSHIP TO PT _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

MEDICAL CONSENT

I voluntarily consent to treatment which may include procedures such as: shave removal biopsy, surgical excision or MOHS surgery. This office visit may include routine, diagnostic procedures including lab/pathology and medical treatment. I also consent to exams, tests, diagnostic and other medical procedures such as blood tests that my physician or physician's assistant may order. I understand that the procedures and treatments at Complete Family Dermatology may be performed by my physician physician's assistant or nursing staff who are members of the Complete Family Dermatology medical staff. I also understand that my physician may request that other health care providers care for me if my physician thinks it is necessary and I consent to their providing such care. I consent to the visual recording of my care for internal purposes to improve health care provider performance and for health care provider education.

PATIENT/RESP PARTY SIGNATURE _____ DATE _____

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to insurance carriers that are pertinent to the above patient's medical care and are necessary to process my insurance claims. I will assign all medical and surgical benefits to Complete Family Dermatology. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I understand and agree that I am ultimately responsible for any unpaid balances. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this assignment at any time by notifying this office in writing.

I also acknowledge that I have received a copy of Complete Family Dermatology "Notice of Privacy Policies."

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ Date _____

How did you first hear about our clinic? _____