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? _____