Print Form

Derm Surgery Associates
General Dermatology · Dermatologic Surgery

PATIENT INFORMATION

Please Print

Today's Date:_____ **Please circle : Male/Female**

Last name:_____First Name:_____Middle Initial:___

Home address:_____City:_____State_____Zip____

Home Phone:_____Daytime Phone:_____Cell: _____

Social Security #_____Date of Birth:_____Marital Status: S/M/D/W

Employer's Name:_____Position:_____

Employer's Address:_____City:_____State_____Zip_____

Primary Care Physician:_____Referring Physician:_____

Emergency Contact Person:_____Home Phone:_____

Work Phone:_____Cell Phone_____Relationship_____

Can we contact you via email? Yes___ No____ Signature_____

Email address:_____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company:_____Phone:_____

******Please present current insurance card to receptionist******

Policy Holder Name:_____Date of birth_____ SS#_____

Policy#:_____Group#:_____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company:_____Phone:_____

******Please present current insurance card to receptionist******

Policy Holder Name:_____Date of birth_____ SS#_____

Policy#:_____Group#:_____

NOTICE TO MANAGED HEALTH CARE PARTICIPANTS

As a Managed Health Care patient it is <u>YOUR RESPONSIBILITY</u> to identify yourself as a PPO HMO or POS patient to our secretary <u>EACH TIME</u> you visit our office. If your POS or HMO plan required for you to obtain pre-authorization from your primary care physician or patient advocate, please provide our office with this information prior to your visit with the doctor, in order to obtain the highest level of benefits. If you fail to obtain prior authorization as directed by your plan you will be responsible for payment at the time services are rendered.

I hereby authorize payment of insurance benefits to be paid directly to Derm Surgery Associates for any services furnished to me. I authorize Derm Surgery Associates to release information to Health Care Financing Administration and its agents, Medicare Champus, or any commercial insurance carrier covered by insurance or prepayment programs.

SIGNATURE:_____DATE:_____