

PATIENT INFORMATION

Please answer completely.

LAST NAME _____ FIRST _____ MI _____ Male Female
STREET _____ CITY _____ STATE _____ ZIP _____
PHONE (HOME) _____ (WORK) _____ (CELL) _____
EMAIL ADDRESS _____ BIRTHDATE _____
SOCIAL SECURITY # _____ RELATIONSHIP TO POLICY HOLDER _____
MARITAL STATUS _____ EMPLOYER/SCHOOL _____
IS ANYONE IN YOUR HOUSEHOLD A PATIENT? Yes No NAME? _____

INSURANCE POLICY HOLDER (if other than patient)

LAST NAME _____ FIRST _____ MI _____ Male Female
STREET _____ CITY _____ STATE _____ ZIP _____
PHONE (Home) _____ (Work) _____ BIRTHDATE _____
SOCIAL SECURITY # _____ EMPLOYER _____
SECONDARY INSURANCE? Yes No CARRIER _____

REFERRAL SOURCE

PRIMARY CARE PHYSICIAN _____ PHONE # _____
ADDRESS _____
DID YOUR PHYSICIAN REFER YOU FOR A CONSULTATION? Yes No
WHERE DID YOU HEAR ABOUT OUR OFFICE ___ Yellow Pages ___ Friend Other _____

EMERGENCY CONTACT

Name: _____ Address: _____ Phone #: _____

AUTHORIZATIONS

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to Yardley Dermatology. I certify that the information I furnish is true and correct.

In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash or check. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered service and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame.

Your signature below communicates your understanding and willingness to comply with this policy.

PATIENT SIGNATURE _____ DATE _____