PATIENT INFORMATION

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name ____

Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

ADDRESS:

Mailing Address ____

City *State* *Zip*

Home Phone: ( )______________________ Work Phone: ( )_______________________

Cell Phone: ( )________________________ e-mail: __________________________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: ____Date of Birth: ____/____/____

Last *First* *M.I.*

Address:____

City *State* *Zip*

Home Phone: ( )______________________ Work Phone: ( )_______________________

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: ____

Secondary Insurance Carrier: ____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I, the patient listed above, authorize and agree to the terms stated in the Authorization and Agreement for Medical Treatment Policy, provided by Clarkston Dermatology & Vein Center. I acknowledge all patient responsibilities and have reviewed these terms. Only services that are considered medically necessary will be billed to my current health insurance. It is my responsibility to keep this office informed of any changes to my health insurance coverage, and to obtain a referral for all medical services, if applicable. I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Date: ____/____/____ Signature: ____

Please provide your insurance card(s) and driver's license to the receptionist along with this