Patient Information Sheet

(Please use black ink)

Today's Date:________________ Who referred you?__________________________________

Patient's Name:____
(Last) (First) (Middle) Jr. / Sr.

Patient's Mailing Address:____
(Street) (Apt.) (City, State) (Zip Code)

Patient's Home Phone #:____________________________ Patient's Cell Phone #:______________________

Patient's Employer:________________________________ Patient's Work Phone #:_____________________

Patient's Social Security #: _________________________ Marital Status: □ M □ W □ D □ S (check one)

Patient Date of Birth: __________________________ Age:_____________ Sex: □ Male □ Female

Guarantor (responsible for minors):____________________________ Relationship to patient:_______________

Primary Insurance Company:____________________________

Primary Policy Holder:_________________________________ Relationship to patient:________________________

Primary Policy Holder's Date of Birth:________________ Primary Policy Holder's SS#:______________________

Secondary Insurance Company:__________________________

Secondary Policy Holder:_______________________________ Relationship to patient:________________________

Secondary Policy Holder's Date of Birth:_______________ Secondary Policy Holder's SS#:___________________

Are you enrolled in Medicaid / QMB in any way? ______ **If so, what?** _____________________________________

If biopsy/lab testing is necessary, may we leave results on your **answering machine**? □ Yes □ No

If biopsy/lab testing is necessary, may we leave results with **another member of your household**? □ Yes □ No
If yes, with whom and what is their relationship to you?____

Preferred Pharmacy and Location:______________________________________ Phone #:____________________

In case of Emergency, whom should we contact (**not living with you**)? ____

Relationship to Patient:______________________

Phone #:_________________________(Home) and Phone #:_______________________(□Work □Cell)

Payment is expected at the time of service for charges not covered by your insurance including office visit co-pays and deductibles. Amarillo Dermatology is not responsible for out-of-network denials or reduced benefit payments. It is the patient's responsibility to verify network benefits. Your signature below indicates that you understand and accept responsibility for the charges not covered by your insurance and authorizes this office to release medical information necessary to process your insurance claim. You authorize payment of medical benefits to AMARILLO DERMATOLOGY when a claim is filed on your behalf. The patient is responsible for lab work and pathology billed by the pathologists that are independent from our office. Amarillo Dermatology charges **$25 for missed appointments** and **appointments cancelled with less than 24 hours notice**.

___________________________________ ________________ **ver03/2018**

Patient (or Responsible Party) Signature Date