PATIENT INFORMATION

NAME: _____ DATE: _____
FIRST MIDDLE LAST

__MINOR __SINGLE __MARRIED __DIVORCED __WIDOWED __SEPARATED

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____

NAME OF PERSON LEGALLY RESPONSIBLE:
(IF PATIENT IS A MINOR, NAME OF PARENT)_____

HOME ADDRESS: _____

_____
CITY STATE ZIP CODE

HOME PHONE: _____ EMAIL:
_____

CELL PHONE: _____

INSURED NAME: _____
INSURED

INSURED DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____

PATIENT'S EMPLOYER:_____ OCCUPATION: _____

WORK ADDRESS: _____

WORK PHONE: _____

INSURED EMPLOYER:_____ OCCUPATION: _____

WORK PHONE:_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:
_____

PHONE: _____

By my signature below, I authorize payment of medical benefits to Glendale Dermatology for all services rendered. This authorization is valid until revoked in writing. I authorize release of any medical information necessary to process claims submitted on my behalf or on the behalf of my children. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.
I agree that I am liable for a $50 fee for any missed appointment without 24-hour prior notice. _____

Signed: _____ Date _____
(insured or authorized person)