CENTRAL COAST DERMATOLOGY

Patient Demographic Form

Thank you for choosing Central Coast Dermatology. In order to serve you properly the following information is needed.
Fill out only the sections that apply to you. All information is confidential.

Please Print Clearly

Patient Information

Date	Patient's Full Name First Middle Last		Name on insurance card
Date of Birth	SS #	Male	Home Phone ( )
Address		Female	Work Phone ( )
City	State Zip		Cell Phone ( )

Emergency Contact Information

Name	Relationship	Phone ( )

Responsible Party

If Patient is a minor child this section MUST be completed.
If not a minor child, the patient above is considered the responsible party and this section does not need to be completed.

Name of person responsible for this account and relationship to the patient	Social Security #	Date of Birth
Address	City	State Zip
Employer	Work Phone ( )	Home Phone ( )

Insurance Information

Name of Insured (Listed on primary on insurance card) List name exactly as shown on insurance card.		
Birth Date	Social Security #	Relationship to Patient.
Name of Employer/Group		Work Phone ( )
Insurance Company	ID #	Group #
Insurance Company Address		

Additional Insurance Information

Name of Insured (Listed on Secondary Insurance Card) List name exactly as shown on insurance card.		
Birth Date	Social Security #	Relationship to Patient
Name of Employer/Group		Relationship to Patient
Insurance Company	ID#	Group #
Insurance Company Address		

Payment in full is required for all services at the time they are rendered, unless you are in a prepaid insurance plan in which we participate. Applicable co-payments and deductibles will be collected. I understand that I am financially responsible for all services rendered that are not paid by my insurances. I agree to pay any undisputed billing from the practice within 30 days of receipt of the bill. I further understand that I may be charged a fee for missed appointments, returned checks, etc, in accordance with the office financial policy.

X _____ _____

Signature of Patient or Parent/Guardian — Date

I authorize the release of information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
For Medicare beneficiaries this serves as a lifetime authorization for release of information.
I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Central Coast Dermatology.
For Medicare beneficiaries this serves as a lifetime authorization assigning payment of Medicare benefits to Central Coast Dermatology.

X _____ _____

Signature of Patient or Parent/Guardian — Date

I have been given a written copy of the "Notice of Privacy Practices" for Central Coast Dermatology.

X _____ _____

Signature of Patient or Parent/Guardian — Date