

PATIENT INFORMATION New Patient Name Change Address Change Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Today's Date ____/____/____

Name _____ Preferred to be called _____
Last First M.I.

Date of Birth: ____/____/____ Age: ____ Sex: Male Female Marital Status: Married Single Divorced Widowed

Employer Name _____ SSN _____
Employer Address _____ Employer Phone No _____

If referred by a Physician: _____
Name of Physician _____ Physician's Address _____

ADDRESS:

Mailing Address _____

Home Phone () _____ Cell Phone () _____ e-mail: _____
City State Zip

Person to contact in case of emergency: _____
Name Address Phone #

To whom may we discuss your care? _____
Name Address Phone #

Has any other member of your family been treated in our office? Yes No

If yes: _____
Name Age Relationship

PARENT, SPOUSE, OR RESPONSIBLE PARTY (If different from patient)

Name: _____ Date of Birth: ____/____/____
Last First M.I.

Address: _____
City State Zip

Home or Cell Phone: () _____ Work Phone: () _____

INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name: _____ Policy # _____

Insurance Address: _____

Name of Policy Holder (Insured) _____
City State Zip Policy Holder's DOB ____/____/____

Group Name or Employer # _____ Relationship to insured: Self Spouse Child

INSURANCE COVERAGE – SECONDARY:

Insurance Co. Name: _____ Policy # _____

Insurance Address: _____

Name of Policy Holder (Insured) _____
City State Zip Policy Holder's DOB ____/____/____

Group Name or Employer # _____ Relationship to insured: Self Spouse Child

In order to establish optimal relations with our patients and avoid misunderstanding regarding our patient policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR CO-PAYMENT OR YOUR PORTION OF THE CHARGES"**. FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. If you do not have insurance, payment in full is expected at the time of service, unless payment arrangements have been made. Balances on all accounts over 90 days are subject to interest charges at the rate of 1.5% per month. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Cheyenne Skin Clinic to release such medical information necessary to process your insurance claims, if any and authorizes payment of medical benefits to the physician when assigned claim is filed.

For Office Use Only
Patient's
Photograph

Signature of Patient or Legal Guardian

Date ____/____/____