

Resp Provider: _____

Southwest Skin Specialists, Ltd.

Patient ID: _____

PATIENT INFORMATION

Sex: M [] F []

Name: _____

Date of Birth: _____ Age: _____

Preferred: _____

Social Security #: _____

Address: _____

Marital Status: Married [] Single [] Divorced [] Widower []

Address: _____

Spouse's Name: _____

City, State, Zip: _____

Referring Physician: _____

Alt Address: _____

Referring Source: _____

Alt City, State, Zip: _____

Primary Physician: _____

Phone: _____

Patient Email: _____

Other: _____

Preferred Pharmacy: _____

Other: _____

Pharmacy Phone: _____

PATIENT EMPLOYMENT Employed [] Retired [] Unemployed [] Other []

EMERGENCY CONTACTS

Employer: _____

Occupation: _____

GUARANTOR Same as Patient []

Name: _____

Social Security #: _____

Address: _____

Date of Birth: _____

City, State, Zip: _____

Relationship to Primary

PRIMARY INSURANCE Same as Patient [] Same as Guarantor [] Other [] Insured/ Guarantor: _____

Insured Party: _____

Insured ID: _____

Insured Phone: _____

Social Security #: _____

Company: _____

Date of Birth: _____

Group ID: _____

SECONDARY INSURANCE Same as Patient [] Same as Guarantor [] Other [] Relationship to Primary

Insured/ Guarantor: _____

Insured Party: _____

Insured ID: _____

Insured Phone: _____

Social Security #: _____

Company: _____

Date of Birth: _____

Group ID: _____

Authorization for treatment and financial agreement: I authorize treatment of the person named below and agree to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within (30) days of the billing date. Although the office may assist me in filing an insurance claim as a courtesy, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorneys' fees and other costs the court may determine proper.

Assignment of benefits and authorization to release information: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to Southwest Skin Specialists, Ltd. and also authorize Southwest Skin Specialists, Ltd. to release any information required in the processing of the insurance claim. I authorize Southwest Skin Specialists, Ltd. to release medical information to my referring physician, primary care physician, spouse, children, parents, any physician he/she may refer me to, or upon my written authorization to any physician I request.

SIGNED: _____ DATE: _____

All Medicare patients must sign the following statement: I request that payment under the Medicare insurance program be made on my behalf to Southwest Skin Specialists, Ltd. for any services furnished me by its Physician(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further permit a copy of the authorization to be used in place of the original.

SIGNED: _____ DATE: _____