Welcome to our office. The following outlines our patient financial responsibility policy.

Payment is required at the time of your visit unless you have evidence of insurance coverage.

Deductibles and copays are payable at time of your office visit. Payment for non-covered services is due at the time of your visit. While we assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require a referral, and payment of the bill.

If you prefer not to supply your social security number, we require full payment at the time of visit.

Please provide our office with accurate insurance information. If it is necessary for us to rebill your insurance company due to incorrect information, there will be a $10.00 rebilling fee.

We do not bill secondary insurances.

Please sign here to acknowledge you have read and understand our policies:

X_____

PATIENT INFORMATION: Mr. ❑ Ms. ❑ Mrs. ❑ Miss ❑

MARITAL STATUS: Single ❑ Married ❑ Widowed ❑ Divorced ❑

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY #

ADDRESS	STREET, APT., P.O. BOX	CITY	ZIP	SEX	BIRTHDATE

HOME PHONE #	EMPLOYER'S NAME	OCCUPATION

EMPLOYER'S ADDRESS	EMPLOYER'S PHONE #

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?	PHONE #

NEAREST RELATIVE (NOT LIVING WITH YOU)	PHONE #
ADDRESS	

RESPONSIBLE PARTY / INSURED'S INFORMATION:

PRIMARY CARRIER INFORMATION:

Patient's relationship to insured: Self ❑ Spouse ❑ Child ❑

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY #

ADDRESS	STREET, APT., P.O. BOX	CITY	ZIP	SEX	BIRTHDATE

HOME PHONE #	EMPLOYER'S NAME	OCCUPATION

EMPLOYER'S ADDRESS	EMPLOYER'S PHONE #

INSURANCE COMPANY	GROUP #	POLICY ID # or SUBSCRIBER #

ADDRESS	STREET, P.O. BOX	CITY	STATE	ZIP

Please fill out information on reverse side

Email _____

Who referred you to our office? _____ Yellow Pages? _____

MEDICAL HISTORY - Please answer all questions

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Asthma	❑	❑	Ulcer	❑	❑	**Women only:**		
Chronic hay fever	❑	❑	Diabetes	❑	❑	Are you pregnant?	❑	❑
Hives	❑	❑	Internal cancer	❑	❑	Expected delivery date _____		
Sinus problems	❑	❑	High blood pressure	❑	❑	Are you breast feeding?	❑	❑
Migraines	❑	❑	Heart trouble	❑	❑	Do you take birth control pills?	❑	❑
Eczema	❑	❑	Rheumatic fever	❑	❑	Which brand? _____		
Boils	❑	❑	Jaundice/Hepatitis	❑	❑			
Food allergies	❑	❑	Kidney disease	❑	❑			
Allergy to local anesthetics	❑	❑	Glaucoma	❑	❑			
Bleeding tendency	❑	❑	Epilepsy	❑	❑			
Tuberculosis	❑	❑						

What diseases, if any, run in your family? _____

_____

Please list all prescription and non-prescription medications you are taking or have taken recently: _____

_____

If you are allergic to any medications please list them: _____

	Yes	No
Have you ever taken penicillin?	❑	❑
Did you ever have a reaction to it?	❑	❑
Have you ever been treated for skin cancer?	❑	❑

Previous skin problems _____

Serious illness or recent hospitalizations _____

_____

ALL PATIENTS PLEASE SIGN

RELEASE AUTHORIZATION/ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS OR TO FACILITATE ONGOING MEDICAL CARE. I ALSO AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN THOSE INSURANCE BENEFITS THAT ARE OTHERWISE PAYABLE TO ME.

THE INFORMATION ABOVE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNED (INSURED PERSON) DATE

CONSENT FOR TREATMENT OF MINOR

(Anyone under 18 years of age today)

For a minor: I consent to have Dr. _____ or his/her associates provide medical care for _____

(NAME OF PATIENT)

In my absence. I ***would or would not*** like to be consulted prior to minor procedures such as mole removal or wart treatments.
(circle one)

_____

(SIGNATURE OF PARENT OR GURADIAN)

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to the physician for any services furnished to me by that physician. 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 benefit payable for the related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the CMS-1500 claim form or the electronically submitted claim is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance and noncovered services.

Insurance and deductibles are based upon the charge determination of the Medicare Carrier.

_____ _____

SIGNATURE DATE