RENCIC DERMATOLOGY

MR# **Today's Date:**

Prefix ❑Mr. ❑ Mrs. ❑Miss ❑Ms. ❑Dr. **Preferred Name**:

Patient's Name:

First Middle Last

Address:

Street & Apt # City State Zip

Birthdate Age: Sex: ❑ Female ❑Male

Marital Status: ❑ Single ❑ Married to: ❑ Other:

Home Phone: Work Phone: Ext: Cell Phone:

Preferred Contact: ❑Home ❑ Work ❑Cell ❑Email **E-mail Address:**

Any restrictions for contacting you? ❑No ❑ Yes If yes, please describe

Emergency Contact: Relationship to Patient: Phone#:

Race: ❑African-American ❑Asian ❑ American Indian/Alaska Native ❑Native Hawaiian or Other Pacific Islander ❑White

Ethnicity: ❑Hispanic ❑Non-Hispanic **Preferred Language:**

Referring Dr.: **Primary Care Dr.:**

INSURANCE INFORMATION

Primary Ins.: Insured: Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB:

Secondary Ins.: Insured: Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB:

RESPONSIBLE PARTY

Name: Address:

Relation to Patient: Birth Date:

PHARMACY

Pharmacy: **Phone:** **Street Name/City/St/Zip:**

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Signature:_____ **Date:** _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. If we file a claim with your insurance you are still responsible for any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

Signature:_____ **Date:** _____