

PATIENT INFORMATION

This information is necessary in order to file claims correctly

Patient Name: _____ Date of Birth: _____
Last First Middle

Address: _____ SSN: _____

Marital Status: S M D W

Sex: M F

City: _____ State: _____ Zip: _____ Home Phone# (____) _____

Employer: _____ Work Phone# (____) _____

Part Time Full Time Retired

Address: _____ Occupation: _____

Family Physician: _____ Phone# _____
First Last

Referring Physician: _____ Phone# _____

Referring Address: _____

PRIMARY INSURANCE POLICY HOLDER INFORMATION OR

Responsible Party if no Insurance or Medicaid Minor

This information is needed in order to file claims correctly

Policy Holder Name: _____ Birth Date: _____
Last First Middle

Policy Holder Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Home Phone# (____) _____

Insured's Employer: _____ Work Phone# (____) _____

Insurance Name: _____ Policy# _____ Group# _____

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

SECONDARY INSURANCE POLICY HOLDER INFORMATION

This information is needed in order to file claims correctly

Policy Holder Name: _____ Birth Date: _____
Last First Middle

Policy Holder Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Home Phone# (____) _____

Insured's Employer: _____ Work Phone# (____) _____

Insurance Name: _____ Policy# _____ Group# _____

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

I hereby authorize my insurance benefits (medical and/or surgical to include major medical benefits) to be paid directly to Beaver Creek Dermatology, LLC. I also recognize that I am responsible to pay for my copays/non-covered services at the time of service. I hereby authorize the release of pertinent medical information to the above named insurance carrier(s).

Signature: _____ Date: _____