PATIENT INFORMATION: (Please use full legal name)

Last Name: ____________________ **First Name:** ____________________ **Middle Initial:** __________

Mailing Address: ____

City: ______________ **State:** __________ **Zip:** __________ **Nickname:** ______________

Home Phone #: ______________ **Social Security Number:** ____________________ **Date of Birth:** __________

Sex: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Other** **Drivers Lic #:** ______________

Employer Name and Address: ____

____ **Work Phone #:** ______________

E-Mail Address: ______________________________ **Cell Phone #:** ______________

Emergency Contact Name and Relationship: ______________________ **Emerg Phone #:** ______________

Primary Care Physician: ______________________ **How did you hear about Perfect Skin?** ______________________

GUARANTOR INFORMATION:

Relationship of Guarantor to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other (Please List)** ______________________

Last Name: ____________________ **First Name:** ____________________ **Middle Initial:** __________

Mailing Address: ____

City: ______________ **State:** __________ **Zip:** __________ **Home Phone #:** ______________

Work Phone #: ______________ **Social Security Number:** ____________________ **Date of Birth:** __________

INSURANCE INFORMATION: (Please have your insurance cards and photo ID ready for the receptionist)

PRIMARY INSURANCE:

Plan Name: ______________________ **Subscriber's Name:** ______________________

Group Number: ______________________ **Policy Number:** ______________________

Subscriber's Address (if different than above): ______________________ **Phone #:** ______________

Subscriber's Date of Birth: ______________ ☐ **Male** ☐ **Female** **Subscriber's Social Security #:** ______________________

Relationship to the Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** __________ **Subscriber's Employer:** ______________________

SECONDARY INSURANCE:

Plan Name: ______________________ **Subscriber's Name:** ______________________

Group Number: ______________________ **Policy Number:** ______________________

Subscriber's Address (if different than above): ______________________ **Phone #:** ______________

Subscriber's Date of Birth: ______________ ☐ **Male** ☐ **Female** **Subscriber's Social Security #:** ______________________

Relationship to the Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** __________ **Subscriber's Employer:** ______________________

By signing below, I authorize treatment from Perfect Skin Dermatology. I authorize my insurance benefits to be paid directly to the physician. I also authorize Perfect Skin Dermatology or my insurance company to release any information required to process my claims. I understand that all co-payments and non-covered or elective services are to be paid at time of service. I understand and agree that I will be responsible for any balance due that Perfect Skin Dermatology is unable to collect from my insurance carrier.

Patient/Guardian Signature:	Printed Name:	Date: