

**Dermatology and Cosmetic Surgery of Dublin, Inc.**

**PATIENT INFORMATION FORM**

Date: \_\_\_\_\_

First, Middle Initial and Last Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Street Address \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Social Security Number \_\_\_\_\_ EMAIL: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

**Check all that apply:**

MALE  FEMALE  MINOR  SINGLE  MARRIED  DIVORCED  WIDOW

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

CHECK IF SAME AS PATIENT – Do not complete if the responsible party is the same as the patient.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth \_\_\_\_\_ Social \_\_\_\_\_

Date \_\_\_\_\_ Security # \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

I **APPROVE** Dermatology and Cosmetic Surgery of Dublin, Inc. to leave telephone messages regarding my pathology results, lab results and returned phone messages on any of the listed below:

Home number  Cell number  Work Number  Email  Other \_\_\_\_\_

I **do NOT approve** Dermatology and Cosmetic Surgery of Dublin, Inc. to leave telephone messages regarding my path results, lab results or returned phone messages.

**DISCLOSURE STATEMENT**

As a courtesy to you, we will file to your insurance company for services our medical providers rendered today. Once payment is received, we will adjust certain balances according to our contracts with your insurance carrier. If we do not have a contract with your insurance carrier, you will be responsible for payment at the time of service.

I have read the above disclosure statement and understand fully that I am responsible for all amounts not covered by my insurance. I also understand that, in the event my insurance carrier does not pay, I am responsible for payment in full. I understand and agree that I will be responsible for all additional charges incurred by Dermatology and Cosmetic Surgery of Dublin, Inc or it's agent to collect my debt.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Representative \_\_\_\_\_ Date \_\_\_\_\_