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 ( ) _____

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 Date _____ Social Security # _____

Address _____

Employer _____ Occupation _____

Home Phone ( ) _____ Work 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 _____