COSMETIC DERMATOLOGY OF GEORGETOWN

PLEASE PRINT **Today's Date**: _____

Full Name (Last, First, M.I.)_____

Primary Phone #: _____Secondary # _____ Work: _____

Date of Birth: _____ Sex: _____ SSN: _____

Marital Status: _____ Name of Spouse/Partner: _____

Home Address: _____

City: _____State: _____ Zip Code: _____

Email Address: _____

May we email personal medical information to you? YES NO

Employer/School Name: _____

Employer Address: _____

Parent or Guardian Name (if Patient is under 18): _____

Other family members seen at this office: _____

Referred By: _____ Relationship: _____

EMERGENCY CONTACT

Full Name: _____ Contact Number: _____

PHARMACY

Pharmacy Name: _____

Phone Number: _____

Pharmacy Address: _____

City: _____State: _____ Zip Code: _____

PATIENT PHYSICIANS

Primary Care Doctor: _____ Phone # _____

Physician's Name	**Specialty**	**Phone #**	**Fax #**

INSURANCE INFORMATION

Patient's Relationship to Policy Holder (circle one): Self Spouse Child Other

Primary Insurance: _____ Is a referral required? Yes No

Policy ID #: _____ Policy Group # _____

Claims Address: _____

Policy Holder - Last Name: _____ First Name: _____

Date of Birth: __/__/__ Social Security #: ___/___/____ Home Phone: _____

Policy Holder Street Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE INFORMATION (FOR PARTICIPATING PLANS ONLY)

Patient's Relationship to Policy Holder (circle one): Self Spouse Child Other

Secondary Insurance: _____ Is a referral required? Yes No

Policy ID #: _____ Policy Group # _____

Claims Address: _____

Policy Holder - Last Name: _____ First Name: _____

Date of Birth: __/__/__ Social Security #: ___/___/____ Home Phone: _____

Policy Holder Street Address: _____

City: _____ State: _____ Zip: _____

PRIOR AUTHORIZATION or REFERRAL RESPONSIBILITY

I understand that if my insurance plan requires prior authorization or a referral for any service, including office visits, it is my responsibility to obtain written authorization or written referral and have the authorization/referral forwarded to Skin, PLLC before my visit. I understand that these forms are not issued retroactively; therefore, I may not be seen if a valid, written authorization or written referral has not been received by Skin, PLLC at the time of my appointment.

_____ _____

Signature of Patient/Parent/Guardian ***Date***

MEDICARE AUTHORIZATION

I hereby authorize Skin, PLLC to submit to Medicare on my behalf for the payment of benefits for services rendered to me by Skin PLLC. I hereby authorize, request and assign payment of Medicare benefits for services rendered to me by Skin, PLLC to be made directly to Skin, PLLC.

_____ _____

Signature of Patient/Parent/Guardian ***Date***