Horizon Dermatology & LASER INSTITUTE

PLEASE PRINT

PATIENT INFORMATION

NAME: FIRST MIDDLE LAST BIRTH DATE ☐ M ☐ F GENDER

HOME ADDRESS CITY STATE ZIP

WORK ADDRESS CITY STATE ZIP

HOME PHONE ( ) WORK PHONE ( ) CELL PHONE ( ) E-mail

SOCIAL SECURITY # – – DRIVER'S LICENSE OCCUPATION

RESPONSIBLE PARTY'S INFORMATION (if different from patient)

NAME: FIRST MIDDLE LAST BIRTH DATE / / SOCIAL SECURITY # – –

ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

MEDICAL INSURANCE INFORMATION (Please present Insurance Card & Driver's License with this form)

INSURANCE NAME

INSURANCE ADDRESS

NAME OF INSURED INSURED ID # GROUP #

INSURED'S SOCIAL SECURITY # – – BIRTH DATE / / REALTIONSHIP TO INSURED

EMERGENCY CONTACT INFORMATION

CONTACT NAME RELATIONSHIP TO CONTACT CONTACT PHONE ( )

ADDRESS CITY STATE ZIP

REFERRED BY PREFERRED PHARMACY PHONE ( )

Do we have permission to:

Leave a message on your answering machine at home? ☐ Yes ☐ No

Leave a message at your place of employment? ☐ Yes ☐ No

Discuss your medical condition with family? ☐ Yes ☐ No

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance application, and prescriptions. I hereby assign my insurance benefits to be made directly to my physician for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. **I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.**

PATIENT OR RESPONSIBLE PARTY SIGNATURE