Horizon Dermatology
& COSMETIC CENTER

**E-Mail**_____

**Patient Information**

Name: _____ DOB: ___/___/____ Age: _____ Sex: M/F
First Middle Last

Home Address: _____
Street City State Zip

Work Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

SSN: _____-_____-_____ Driver's License: _____ Occupation: _____

**RESPONSIBLE PARTY INFORMATION** (IF DIFFERENT FROM PATIENT)

NAME: _____ SSN: _____

Address: _____ DOB: ____/_____/_____

Home Phone_____ Work Phone_____ Cell Phone: _____

**INSURANCE INFORMATION (Please present Insurance Card and Driver's License at time of check-in)**

Insurance Name: _____

Insurance Address: _____

Name of Insured: _____Insured ID #_____Group #_____

Insured's SSN#_____-_____-_____DOB____/____/_____ Relationship to Insured: _____

**IN EMERGENCY, WHOM MAY WE CONTACT?**

Name: _____ Relationship: _____Phone: _____

Address: _____

Referred By: _____

Preferred Pharmacy: _____Zip Code_____ 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**_____