FIXLER DERMATOLOGY, INC. - PATIENT INFORMATION

*Referred by Dr.*_________________________________ Today's Date ___/___/___

Name ____
Last *First* *M.I.*

Mailing Address ____
City *State* *Zip*

Home Phone ____________________ Work Phone ____________________ SS# ________________
Area Code *Area Code*

Date of Birth ___/___/___ Age______ Sex______ Marital Status ______ Race______________

Employer Name & Address_________________________________ Occupation______________

SPOUSE - PARENT OR RESPONSIBLE PARTY

Name ____
Last *First* *M.I.*

Address ____
City *State* *Zip*

Home Phone ____________________ Work Phone ____________________ SS# ________________
Area Code *Area Code*

Date of Birth___/___/___ Sex__________

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance Name	**Secondary** Insurance Name
Ins. Address	Ins. Address
Name of Insured	Name of Insured
Insured's ID#	Insured's ID#
Group #	Group #
Employer Name	Employer Name
Employer Address	Employer Address
Employer Phone	Employer Phone
Employer Phone *Area Code*	Employer Phone *Area Code*

Relationship of patient to the Insured ______________ Relationship of patient to the Insured ___________

In case of Emergency, who should be notified?________________________ Phone ________________

Primary Care Physician (Name & Address)____

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 applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ______________________________ Date ___/___/___

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash or check. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy. Patient is responsible for any referrals required by your Insurance Company.

Patient or Responsible Party Signature ______________________________ Date ___/___/___