MIDDLEBELT DERMATOLOGY CENTER

PLEASE PRINT ALL INFORMATION

PATIENT NAME_____ SEX M F
LAST FIRST INITIAL

HOME ADDRESS_____APT#_____CITY_____

STATE_____ZIP CODE_____PHONE( )_____HEIGHT_____WT____

AGE_____ BIRTHDATE_____ SS#_____MARITAL STATUS: M S W D

EMPLOYER_____ EMP. PH ( )_____

OCCUPATION_____ EMERGENCY PH #_____
RELATIONSHIP

Parent or guardian accompanying the patient

NAME_____SS#_____DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE ( )_____ EMPLOYER PH# ( )_____

DRIVERS LIC #_____RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME_____

CARD HOLDERS NAME_____DATE OF BIRTH_____

SS#_____EMPLOYER_____PHONE_____

RELATIONSHIP TO PATIENT_____ GROUP#_____

CONTRACT#_____

SECOND INSURANCE NAME_____

CARD HOLDERS NAME_____DATE OF BIRTH_____

SS#_____EMPLOYER_____PHONE_____

RELATIONSHIP TO PATIENT_____GROUP#_____

CONTRACT#_____

WHO REFERRED YOU TO OUR OFFICE?_____
FAMILY DOCTOR_____

I AUTHORIZE MY INSURANCE COMPANY TO RELEASE PAYMENT DIRECTLY TO DR. MAHON. I ALSO GIVE MY PERMISSION TO ALLOW MIDDLEBELT DERMATOLOGY CENTER TO RELEASE MY MEDICAL RECORDS TO MY INSURANCE COMPANY IF REQUESTED IN ORDER TO RECEIVE PAYMENT. I ALSO UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES, AND / OR NON COVERED SERVICES PERFORMED TO ME AT MIDDLEBELT DERMATOLOGY CENTER.

SIGNATURE OF RESPONSIBLE PARTY_____DATE_____