

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F Mar. Status \_\_\_\_\_  
Last Name First Name M.I.

Address \_\_\_\_\_  
Street address City State Zip +four

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation: \_\_\_\_\_ Employment Status: FT PT NONE Student Status: FT PT NONE

**RESPONSIBLE PARTY: (If patient is a minor)**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip +four

**PRIMARY INSURANCE**

Subscriber Name: \_\_\_\_\_ Subscriber birthdate \_\_\_\_\_

Group# \_\_\_\_\_ Insured's ID# \_\_\_\_\_ Relation to Subscriber \_\_\_\_\_

Employer Name \_\_\_\_\_ City \_\_\_\_\_

**SECOND INSURANCE**

Subscriber Name: \_\_\_\_\_ Subscriber birthdate \_\_\_\_\_

Group# \_\_\_\_\_ Insured's ID# \_\_\_\_\_ Relation to Subscriber \_\_\_\_\_

In case of Emergency, who should be notified: \_\_\_\_\_ Phone \_\_\_\_\_

Other Family members who are patients \_\_\_\_\_

Pharmacy of Choice \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Did they refer you? \_\_\_\_\_

**Release of Medical/Financial Information** - You must give us permission to talk with others about your medical care or billing information. Unless their name is listed below, we may not speak to them about your care or your bill. Please indicate your emergency contact.

_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name	Relationship	Home Phone	Mobile Phone	Medical	Billing	ER contact

_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name	Relationship	Home Phone	Mobile Phone	Medical	Billing	ER contact

**Your Privacy:**

**I have been informed of the Notice of Privacy Practices for Dermatology Center of Grand Rapids, P.C.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Financial Policy:** Patients who are covered by a private, commercial plans in which our physicians do not participate are required to pay 100% of the bill at the time of service. If covered by a plan with whom we have a contract, applicable co-payments and deductibles will be collected at the time of service, if determinable. You are responsible for paying for 100% of non-covered or cosmetic services. Payment for amounts billed to you are due within 20 days of receiving a statement. Your signature indicates your willingness to comply with this policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Authorization for Payment:** I authorize the release of information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits directly to the physician.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Special Authorization for Medicare Patients Only:**

I request that payment of authorized Medicare benefits be made on my behalf to The Dermatology Center of Grand Rapids, for any services furnished me by their providers. I authorize the release of information to the Centers for Medicare and Medicaid Services and its agents in order to determine benefits and payment of the claim. If "other health insurance" is indicated I authorize releasing of the information to the insurer or agency shown. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for co-insurance and deductible amounts as directed by my Medicare carrier. (Dermatology Center of Grand Rapids, PC is a participating provider.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Would you like to be notified by email about cosmetic service or product specials we offer?**

\_\_\_\_\_  
email address

**How did you hear about us?   Doctor   Friend   Family Member   Yellow Pages**