PATIENT PROFILE

Doctor: ____________________

PATIENT INFORMATION

Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: (home) ____________________ -

(cell) ____________________

(work) ____________________

Email: ____________________

Patient ID #: __________ Sex: [ ] M [ ] F

Date of Birth: ____________________

Soc. Sec. #: ____________________

Martial Status: ____________________

Referring Physician: ____________________

Primary Physician: ____________________

EMERGENCY CONTACTS

____

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PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Other

Employer: ____________________

Phone: ____________________

RESPONSIBLE PARTY EMPLOYER INFORMATION

Employer: ____________________

Phone: ____________________

Soc. Sec. #: ____________________

Date of Birth: ____________________

RESPONSIBLE PARTY

[ ] Same as Patient

Name: ____________________

Address: ____________________

City, State, Zip: ____________________

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: ____________________

Company: ____________________

Relationship to Patient: ____________________

Insured ID: ____________________

Policy Group: ____________________

Date of Birth: ____________________

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: ____________________

Company: ____________________

Relationship to Patient: ____________________

Insured ID: ____________________

Policy Group: ____________________

Date of Birth: ____________________

Email Authorization: I consent for Spokane Dermatology Clinic/Constant Contact (3rd party email comp.) to use my email address provided for:

☐ Special events, promotions, and/or specials on products and services (signature on separate form required)

Release of Benefits and Information: I consent for medical treatment and I have verified the insurance listed on this slip and authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or the insurance company to release any information required for this claim. I understand that I am responsible if my insurance plan requires a referral, to assure that I have a referral for medical treatment. I have read and understand the office insurance/payment policy stated above.

Signed: ____________________ **Date:** ____________________