PATIENT INFORMATION

Today's Date: ____________________ Email Address: ________________________________

Patient Name: ____
Last First MI

Mailing Address: ____
City State Zip

Home Telephone: ________________________Cell Phone: ______________________________

Gender:☐Male☐Female Date of Birth: ___________________________Age: _____________

Social Security #: _____________________ Driver's License #: _________________________

Marital Status:☐Single ☐Married☐Divorced☐Separated☐Widowed

Preferred Language:☐ English ☐ Spanish ☐ Other: ____________________________________

Who may we call in case of an emergency? ____________________ Phone #: ______________

Nearest Relative Not Living with you: ________________________ Phone #:_______________

Primary Care Physician: ___________________________________Phone #: ______________

INFORMATION ABOUT THE PERRSON RESPONSIBLE FOR ANY BILL

(Fill out if different from patient.)

Responsible Person's Name: ____
Last First MI

Mailing Address: ____
City State Zip

Home Telephone: ________________________Cell Phone: ______________________________

Gender:☐Male☐Female Date of Birth: ___________________________Age: _____________

Social Security #: _____________________ Driver's License #: _________________________

Marital Status:☐Single ☐Married☐Divorced☐Separated☐Widowed

Relationship to Patient: Spouse ☐ Parent Other _________________________

AUTHORIZATION OF MEDICAL RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process my insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits to Chico Dermatology and its Medical Providers for medical services provided to me or my dependent.

Responsible Person's Signature ___________________________________Date:_________________

PLEASE TURN THE PAGE OVER FOR MORE INFORMATION NEEDED.

PAYMENT TERMS

Payment is required for all services at the time they are rendered unless Chico Dermatology and/or any of its Medical Providers are contracted providers of your insurance company. If you participate in a contracted insurance plan, applicable co-payments, deductibles and payment of non-covered services is required to be paid in full at the time the services are rendered.

If you do not participate in a contracted insurance plan, payment is required in full at the time services are rendered. We can mail an insurance bill on your behalf so your insurance can reimburse you. Our office will not bill your non-contracted insurance in lieu of your payment in full.

We accept payment in the form of cash, check, or credit card. All returned checks are subject to a $25.00 service fee per check and the payer is responsible for value of the check and fees.

Your signature below signifies your understanding and willingness to comply with these payment terms.

Responsible Person's Signature ____________________________________Date:_____________________