Account #_____

SKIN CARE PHYSICIANS

Gail B. Whitman, MD **Denise Gallo, APRN**

(Please Print)

PATIENT INFORMATION

Date _____

Name _____
Last First MI

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____
Area Code Area Code Area Code

Date of Birth_____ Sex _____ SS# _____ Marital Status_____

Employer _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First MI

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____
Area Code Area Code Area Code

Date of Birth _____ Sex _____

INSURANCE INFORMATION (Please present insurance card)

Primary Insurance Name _____

Name of Insured _____

Insured's Address _____

Insured's Phone Number _____

Insured's SSN: _____

Insured's Date of Birth: _____

Employer's Name _____

Relationship of patient to insured _____

Secondary Insurance Name _____

Name of Insured _____

Insured's Address _____

Insured's Phone Number _____

Insured's SSN: _____

Insured's Date of Birth: _____

Employer's Name _____

Relationship of patient to insured _____

Other family members that are patients _____

Pharmacy _____ Address _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____ Address: _____

Primary Care Physician _____ Address _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? _____

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 deductible, will be collected. We accept payment in the form of cash, check, or credit card. 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 must notify us within 5 days of any change of insurance.**

Patient or Responsible Party Signature _____ Date _____