

DEL MAR DERMATOLOGY

<i>Today's Date</i>	<i>Are you a new Patient?</i> YES NO	<i>Who were you referred by?</i>	<i>Phone #</i> ()
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PATIENT INFORMATION

<i>PATIENT'S NAME (LAST NAME, FIRST NAME, M.I.)</i>		
<i>RESPONSIBLE PARTY'S NAME – IF NOT THE PATIENT (LAST NAME, FIRST NAME, M.I.)</i>		
<i>BILLING ADDRESS</i>	<i>CITY</i>	<i>STATE ZIP</i>
<i>PERMANENT ADDRESS (if different)</i>	<i>CITY</i>	<i>STATE ZIP</i>
<i>HOME PHONE</i> () -	<i>WORK PHONE</i> () -	<i>CELL PHONE</i> () -
<i>SEX</i> MALE FEMALE	<i>BIRTHDAY</i>	<i>PATIENT SOCIAL SECURITY #</i>
<i>RELATIONSHIP OF PATIENT TO RESPONSIBLE PARTY</i> SELF SPOUSE CHILD OTHER(SPECIFY) _____	<i>MARITAL STATUS</i> SINGLE MARRIED REGISTERED DOMESTIC PARTNER	
<i>PATIENT'S OCCUPATION AND EMPLOYER</i>		

INSURANCE INFORMATION

(PLEASE PROVIDE COPIES OF ALL I.D. CARDS – FRONT AND BACK, IF APPLICABLE)

Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or third party payer. It is your responsibility to know if this is true. If you are not sure, the office staff may be able to assist you.

PLEASE CHECK HERE IF YOU HAVE NO INSURANCE AND YOU WILL BE SOLELY RESPONSIBLE FOR PAYMENT

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
<i>INSURANCE PHONE #</i> () -	<i>EFFECTIVE DATE</i>	<i>INSURANCE PHONE #</i> () -	<i>EFFECTIVE DATE</i>
<i>CLAIMS ADDRESS</i>		<i>CLAIMS ADDRESS</i>	
<i>SUBSCRIBER NAME</i>	<i>DATE OF BIRTH</i>	<i>SUBSCRIBER NAME</i>	<i>DATE OF BIRTH</i>
<i>SUBSCRIBER ID #</i>	<i>GROUP #</i>	<i>SUBSCRIBER ID #</i>	<i>GROUP #</i>
<i>RELATIONSHIP OF SUBSCRIBER TO PATIENT</i> SELF SPOUSE CHILD OTHER _____		<i>RELATIONSHIP OF SUBSCRIBER TO PATIENT</i> SELF SPOUSE CHILD OTHER _____	

