PATIENT INFORMATION □ New Patient □ Name Change □ Address Change □ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date_____/_____/_____

Name_____Preferred to be called_____
Last *First* *M.I.*

Date of Birth:_____/_____/_____ Age:_____ Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Widowed

_____ **SSN**_____
Employer Name Employer Address Employer Phone No

If referred by a Physician:_____
Name of Physician Physician's Address

ADDRESS:

Mailing Address_____
City *State* *Zip*

Home Phone ( )_____ Cell Phone ( )_____e-mail:_____

Person to contact in case of emergency:_____
Name *Address* *Phone #*

To whom may we discuss your care?_____
Name *Address* *Phone #*

Has any other member of your family been treated in our office? □ Yes □ No

If yes:_____
Name *Age* *Relationship*

PARENT, SPOUSE, OR RESPONSIBLE PARTY (If different from patient)

Name:_____Date of Birth:_____/_____/_____
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home or Cell Phone: ( )_____Work Phone: ( )_____

INSURANCE COVERAGE – <u>PRIMARY:</u>

Insurance Co. Name:_____ Policy #_____

Insurance Addresss:_____
City *State* *Zip*

Name of Policy Holder (Insured)_____Policy Holder's DOB _____/_____/_____

Group Name or Employer #_____Relationship to insured: □ Self □ Spouse □ Child

INSURANCE COVERAGE – <u>SECONDARY;</u>

Insurance Co. Name:_____ Policy #_____

Insurance Addresss:_____
City *State* *Zip*

Name of Policy Holder (Insured)_____Policy Holder's DOB _____/_____/_____

Group Name or Employer #_____Relationship to insured: □ Self □ Spouse □ Child

In order to establish optimal relations with our patients and avoid misunderstanding regarding our patient policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS **EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR CO-PAYMENT OR YOUR PORTION OF THE CHARGES"**. FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. If you do not have insurance, payment in full is expected at the time of service, unless payment arrangements have been made. Balances on all accounts not secured with valid credit card on file will be subject to statement fees and interest as defined on CSC's Credit Card policy sheet. Any account turned over to collection agency for non-payment will be subject to added collection costs and attorney fees. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Cheyenne Skin Clinic to release such medical information necessary to process your insurance claims, if any and authorizes payment of medical benefits to the physician when assigned claim is filed.

For Office Use Only
Patient's
Photograph

_____ Date_____/_____/_____
Signature of Patient or Legal Guardian