SEITZ DERMATOLOGY NEW PATIENT

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____-_____-_____ Sex: _____ Email: _____

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Marital Status: _____ Race: _____ Ethnicity: _____ Language: _____

Primary Doctor (Care Provider): _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Name: _____ DOB: _____ SSN: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Race: _____ Ethnicity: _____ Language: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____

Relationship to Patient: _____ Phone Number: _____

***Okay to share medical information with this contact: (Circle) Yes or No

FILL OUT INSURANCE INFORMATION

Primary Insurance Company Name: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-_____-_____

Policy Number: _____ Relationship to Insured: _____

Secondary Insurance Company Name: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-____-_____

Policy Number: _____ Relationship to Insured: _____

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to SEITZ DERMATOLOGY. I understand payment is due at the time of service.

Signature of Patient/Guardian: _____ Date: _____