

Glaser Dermatology

PLEASE PROVIDE ALL REQUESTED INFORMATION

Patient Name: _____ Home Phone: () _____
(Last) (First) (Mid. Init.)

Address: _____ Apt: _____ Work Phone: () _____ ext _____

City: _____ State: _____ Zip: _____ Cell Phone: () _____

Sex: M F Marital Status (circle): single married divorced Date of Birth: ____/____/____

SS #: ____ - ____ - _____ Pharmacy Name & Town: _____ Phone: () _____

Employer Name: _____ Primary Doctor: _____ Phone: () _____

Referred by (fill in the blank): Dr _____ Patient _____

Relative _____ Other _____ Insurance Plan _____

INSURANCE INFORMATION (PLEASE SHOW US YOUR INSURANCE ID CARDS)

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber SS#: ____ - ____ - _____ DOB: _____ Subscriber SS#: ____ - ____ - _____ DOB: _____

Subscriber ID#: _____ Group #: _____ Subscriber ID#: _____ Group #: _____

RESPONSIBLE PARTY INFORMATION (if same as the patient, please write "same as above")

Patient Name: _____ Home Phone: () _____
(Last) (First) (Mid. Init.)

Address: _____ Apt: _____ Work Phone: () _____ ext _____

City: _____ State: _____ Zip: _____ Cell Phone: () _____

SS #: ____ - ____ - _____ Date of Birth: ____/____/____ Employer Name: _____

Relationship to Patient: Spouse Parent Other: _____

I authorize Glaser Dermatology to furnish all medical records for insurance claim reviews. I accept financial responsibility for my insurance's deductibles, co-pays, & co-insurances; and for denials due to inaccurately provided insurance information, a non-participating plan, a lapse in coverage, and for non-covered services. **I understand that I must provide my complete and accurate insurance coverage information at check-in to avoid being held responsible for insurance denials.** To recover unpaid amounts, I agree that all legal costs will be added to the amount I owe, including court filing & attorney fees (the latter being 33-1/3% of amount owed plus interest at 1-1/2% per month, per annum).

Authorized Signature: _____ Date: _____

Relationship to Patient: _____

Emergency contact: _____ Tel () _____ Relationship _____