Advanced Dermatology of Oregon

INFORMATION

Name: _____

Address: _____

_____

City,State Zip: _____

Phone: _____ [ ]Home [ ]Work [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Other

Doctor: _____

Patient ID #: _____ **Sex:** [ ]M [ ]F

Date of Birth: _____

Social Security #: _____

Marital Status: [ ]Married [ ]Single [ ]Divorced

Referring Physican: _____

Primary Physician: _____

FINANCIALLY REPONSIBLE PARTY

[ ]Same as Patient

Name: _____

Address: _____

_____

City,State: _____

EMPLOYMENT

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Ins Company: _____

Ins Address: _____

Patient Relationship to Insured Party: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Ins Company: _____

Ins Address: _____

Patient Relationship to Insured Party: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

PRIOR AUTHORIZATIONS/THIRD PARTY LIABILITY INSURANCE INFORMATION:

Date of Injury: _____ W/C Employer: _____

Claim #: _____ W/C Insurance Co.: _____

W/C Ins Address: _____

Description: _____

Authorization #: _____ Auth Expiration Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to Advanced Dermatology of Oregon, and authorize them to furnish information regarding my treatment to my insurance company. I understand that my contract with my insurance company requires me to be compliant to the rules of my policy regarding referrals to medical specialists.

I understand that I am responsible for any amount not paid for by my insurance. I am responsible for all known visit co-pays at the time of service. There will be a $25 no show fee for all visits not cancelled with 24 hr notice.

_____

Patient/Responsible Party Signature Date