complete skin md

Patient Profile

First Name: _____ Last Name:_____

Gender: Select Marital Status: Select one Race/Ethnicity (optional): _____

Home Street Address:

_____

City: _____ State: _____ Zip code: _____

Email: _____ D.O.B: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Employer name: _____

Referring MD: _____ Primary Care MD: _____

Referral Source (if other): _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

Preferred method of confirmation: Email: ☑ Text: ☐ Phone call: ☐

PRIMARY INSURANCE INFORMATION:

Carrier: _____ Policy ID: _____

SECONDARY INSURANCE INFORMATION:

Carrier: _____ Policy ID: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Complete Skin MD to bill the above referenced health insurance to my behalf for any/all services performed. I hereby assign all insurance payment benefits directly to this physician group should they accept assignment to my insurance carriers. I understand that any payments that I may receipt directly, for services which were billed on my behalf by the physicians, must be turned over to the physician. I understand that I am financially responsible for any/all charges not payable by my insurance carriers. I hereby authorize the release of any information necessary to secure payment of benefits.

_____ _____

Patient Signature Date