

Dermatology Group of Southern California
Dermatology § Skin Cancer Surgery § Laser Surgery

5525 Etiwanda Avenue, Suite 308
Tarzana, CA 91356

PATIENT INFORMATION

(Please print clearly)

Today's Date: ____/____/____

Name: _____ SS#:_____/_____/_____ Sex: M/F (circle one)
Last First M.I.

Mailing Address: _____
City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ Driver's Lic. #: _____ Exp. Date: _____
Cell Phone: (____) _____

Date of Birth: ____/____/____ Age: _____ Martial Status: (M S W D) If Student, FT or PT: School _____

E-mail address: _____

PRIMARY SUBSCRIBER OF INSURANCE/RESPONSIBLE PARTY (If different from patient)

Name: _____
Last First M.I.

Mailing Address: _____
City State Zip

Home Phone :(____) _____ Work Phone :(____) _____ SS#:_____/_____/_____ Date of Birth: ____/____/____

Age: _____ Sex: M/F (circle one) Driver's Lic. #: _____ ST: _____ Exp. Date: _____

INSURANCE INFORMATION (Please present insurance card at time of check in and secondary information for Medicare Patients Only.)

Primary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group# _____

Employer Name _____

Employer Address _____

Employer Phone (____) _____

Relationship of patient to the Insured _____

Secondary Insurance Name _____

Ins. Address _____

Name of Insured _____

Insured's ID# _____

Group# _____

Employer Name _____

Employer Address _____

Employer Phone (____) _____

Relationship of patient to the Insured _____

Do we have your permission to:

Leave a message on your home or cell phone number?

YES NO

Leave a message at your place of employment?

YES NO

Discuss your medical condition with any member of your household?

YES NO

If yes, whom: _____

Relationship: _____

In case of Emergency, who should be notified? _____ Phone (____) _____

Referred by: _____ Primary Care Physician: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorized payment of medical benefits to Roy B. Blumenstrauch, M.D., Inc.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. A \$10.00 billing fee may be assessed if co-payment is not paid at time of visit. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be reverified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to a collection agency, I will be responsible for attorney fees not to exceed 15% of the outstanding balance plus court costs and any other cost pertaining to the outstanding balance. **There is a \$30.00 fee for each check returned from the bank. There is a \$30.00 fee for missed appointments without 24-hour notification.**

Patient or Responsible Party Signature _____ Date _____

Entered by: _____ Acct#: _____ Ins Verified by: _____ Date: _____