PLEASE PRINT

PLEASE PRINT

DATE	ACCOUNT NUMBER	PATIENT EMAIL ADDRESS

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

PATIENT'S FULL NAME	SOC. SEC. NO.	SEX (M / F)	DATE OF BIRTH	AGE
			/ /	

MAILING ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE	CELL PHONE

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) ☐ PART TIME ☐ FULL TIME	MARITAL STATUS (S / M / W / D / SEP)

EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	BUSINESS PHONE

SPOUSE'S OR PARENT'S NAME	SOC. SEC. NO.	DATE OF BIRTH	CELL PHONE
		/ /	

SPOUSE'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT) ☐ PART TIME ☐ FULL TIME	BUSINESS PHONE

RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY	SOC. SEC. NO.	DATE OF BIRTH	HOME PHONE	CELL / WORK PHONE
		/ /		

MAILING ADDRESS	CITY, STATE, ZIP CODE	RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S EMPLOYER	CITY, STATE OF EMPLOYER	BUSINESS PHONE

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO.	CO-PAY	CONTRACT NO.	GROUP NO.	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) DATE OF BIRTH

NAME OF SECONDARY INSURANCE CO.	CO-PAY	CONTRACT NO.	GROUP NO.	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD) DATE OF BIRTH

ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE? YES / NO	IF YES: NAME OF INSURANCE CO.	CONTRACT NO.	GROUP NO.

Co-Pay Form of Payment Cash ( ) Check ( ) Credit or Debit Card ( ) Number: _____

Expiration Date: _____ Name on Card if other patient _____

Authorizing Signature: _____ Date: _____

AUTH. DATE: _____ AUTH. DATE: _____ AUTH. DATE: _____

INITIALS: _____ INITIALS: _____ INITIALS: _____

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

NAME	HOME PHONE	CELL / WORK PHONE	RELATIONSHIP

MAILING ADDRESS	CITY, STATE, ZIP CODE

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I HEREBY AUTHORIZE SOUTHERN SKIES DERMATOLOGY AND SURGERY TO RELEASE ANY AND ALL INFORMATION ACQUIRED IN MY EXAMINATION AND TREATMENT TO MY INSURER LISTED ABOVE. IF I AM COVERED BY BLUE CROSS, MEDICARE AND/OR MEDICAID I WILL FURNISH MY INSURANCE CARD AND SIGNATURE. IF I AM COVERED BY OTHER INSURANCE, I WILL FURNISH THE NECESSARY FORMS TO THIS OFFICE.

I HEREBY ASSIGN AND AUTHORIZE PAYMENT DIRECTLY TO SOUTHERN SKIES DERMATOLOGY AND SURGERY ANY MEDICAL AND SURGICAL BENEFITS OTHERWISE PAYABLE TO ME. SHOULD AN INSURANCE PAYMENT BE RECEIVED THAT IS LESS THAN THE PHYSICIAN'S USUAL CHARGE FOR THE SERVICES PROVIDED, I WILL BE RESPONSIBLE FOR THE DIFFERENCE.

I ALSO AGREE TO PAY ALL COST OF COLLECTION INCLUDING, BUT NOT LIMITED TO REASONABLE ATTORNEY'S FEES, AND WAIVER ALL CLAIMS OF EXEMPTION UNDER THE LAW OF THE STATE OF ALABAMA.

I AUTHORIZE TREATMENT BY SOUTHERN SKIES DERMATOLOGY AND SURGERY PHYSICIANS AND PERSONNEL. _____

FORM MUST BE SIGNED AND DATED BY PATIENT OR RESPONSIBLE PARTY. PATIENT/PARENT SIGNATURE

DATED AT _____ THIS _____ DAY OF _____, 20 _____

SIGNATURE OF POLICYHOLDER

SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER.