NAME

 First Middle Initial Last

Please Circle: Male Female Single Married Divorced Widowed

ADDRESS

Street

City State Zip

Home Phone Cell Work

Email: Social Security #

Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Spouse’s Name

Occupation Family Doctor

Name of Person Responsible for Payment

Address if different than above

MEDICAL INSURANCE

PRIMARY Insurance Company

Membership # Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay

Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Relationship of Patient to Policy Holder (Circle One) SELF SPOUSE CHILD DOMESTIC

 PARTNER

OTHER

SECONDARY Insurance Company

Membership # Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay

Name of Policy Holder Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Relationship of Patient to Policy Holder (Circle One) SELF SPOUSE CHILD DOMESTIC

 PARTNER

OTHER

REFERRED TO THIS OFFICE BY

* **IF WE NEED TO CALL YOU ABOUT YOUR MEDICAL CONDITION, WHICH SHOULD WE DO?**

* Call you at WORK Call you at HOME Either
* Other than yourself, may we: Talk to your SPOUSE , and/or
* Name(s): Please INITIAL

I authorize release of any medical information necessary to process this claim. I authorize payment of medical benefits to Robinson & Max Dermatology PA.

SIGNED DATE

**PAYMENT IS EXPECTED AT THE TIME OF VISIT.**

**WE WILL BE HAPPY TO ASSIST YOU IN FILLING OUT INSURANCE CLAIMS.**