Central Coast Dermatology

Thank you for choosing *Central Coast Dermatology*. In order for us to serve you properly the following information is needed.
Fill out only the sections that apply to you. All information in confidential.
PLEASE PRINT CLEARLY

Patient Information

Date	Patient's Full Name (First, Middle, Last)		Name on Insurance Card
Date of Birth	SS#	Male	Home Phone
Address		Female	Work Phone
City	State	Zip Code	Cell Phone
Race	Ethnicity	Language	Email address

Emergency Contact Information

Name	Relationship	Phone

Responsible Party

If Patient is a minor child this section MUST be completed. If not a minor child, the patient is considered the responsible party and this section does not need to be completed.

Name		SS#	Date of Birth
Address	City	State	Zip Code
Employer	Work Phone	Home Phone	

Insurance Information

Name of Insured (exactly as shown on insurance card)		
Birth Date	SS#	Relationship to Patient
Name of Employer/Group	Work Phone	
Insurance Company	ID#	Group#
Insurance Company Address		

Additional Insurance Information

Name of Insured (exactly as shown on insurance card)		
Birth Date	SS#	Relationship to Patient
Name of Employer/Group	Work Phone	
Insurance Company	ID#	Group#
Insurance Company Address		

Payment in full is required for all services at the time they are rendered, unless you are in a prepaid insurance plan in which we participate. Applicable co-payments and deductibles will be collected. I understand that I am financially responsible for all services rendered that are not paid by my insurances. I agree to pay any undisputed billing from the practice within 30 days of receipt of the bill. I further understand that I may be charged a fee for missed appointments, returned checks, etc, in accordance with the financial policy.

X _____ **X** _____

Signature of patient/parent or guardian **date**

I authorize the release of information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for my insurance. For Medicare beneficiaries this serves as a lifetime authorization for release of information. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Central Coast Dermatology. For Medicare beneficiaries this serves as a lifetime authorization assigning payment of Medicare benefits to Central Coast Dermatology.

X _____ **X** _____

Signature of patient/parent or guardian **date**

I have been given a written copy of the "Notice of Privacy Practices" for Central Coast Dermatology.

X _____ **X** _____

Signature of patient/parent or guardian **date**