

**English Dermatology**

PLEASE PRINT

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_  
Name Address Phone Occupation

Emergency Contact \_\_\_\_\_  
Name Phone Relation

**REFERRAL SOURCE**

Referred by:  
\_\_\_\_ Physician/Provider Name \_\_\_\_\_

\_\_\_\_ Friend/Relative Name \_\_\_\_\_

\_\_\_\_ Other Please Specify \_\_\_\_\_  
Examples: Health Plan/Insurance Company, Yellow Pages, Internet, Go Gilbert Magazine

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

**GUARANTOR/RESPONSIBLE PARTY (If different from patient)**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_  
Name Address Phone Occupation

**AUTHORIZATION, ASSIGNMENT & CONSENT TO TREAT**

The patient or authorized person agrees that the above information is correct and allows for the medical treatment as specified by physician or associate provider.

I hereby authorize English Dermatology to release any information requested, including medical information, to any insurance company, employer, third party payer, or third party administrator for purposes of processing my claims. I hereby assign English Dermatology ALL payments for medical services rendered to myself or dependents. As the responsible party, I agree that I am responsible for ANY unpaid amounts, and agree to pay service charges at the current rate, collection charges, bad check charges, and court costs including any reasonable attorney fees.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_