

# Alamance Skin Center

## Patient Information Sheet

Chart Number: \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (If different from above) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex ( ) Male ( ) Female Marital Status \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Spouse Information: Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Please list the adult responsible for payment if patient is a minor or dependent

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

### IT IS IMPERATIVE WE RECEIVE COMPLETE INSURANCE INFORMATION IN ORDER TO FILE!

Primary Insurance Company \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Relation to patient \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Policy Holder's SS# \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Relation to patient \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Policy Holder's SS# \_\_\_\_\_

Were you referred by another physician?  yes  no Physician's Name \_\_\_\_\_

Pharmacy Preference \_\_\_\_\_

I authorize Alamance Skin Center to release to my insurance company any information acquired in the course of my examination and treatment regarding my condition.

Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment from my insurance company directly to Alamance Skin Center and accept full responsibility for any portion of the charge not paid for by my insurance company for all services rendered to me in the course of my treatment.

Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed a copy of Alamance Skin Center's Notice of Privacy Practices. I may request a copy for my records.

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

By listing the name of an individual or physician you are giving permission for that party to receive information about the care of the above named patient. This permission includes picking up prescriptions, sample products, etc.

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