UNIVERSITY DERMATOLOGY
Cosmetic & Surgery Center

PLEASE PRINT THE INFORMATION BELOW

Last Name: _____ First Name: _____ MI _____

Preferred Name/Nickname: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: **M** **or** **F** (please circle)

Social Security #: _____ - _____ - _____

Employer/School: _____

Are You Married? **YES** **or** **NO** (please circle)

Pharmacy Phone #: _____

If Minor, In care of: _____ Relationship to Patient: _____

Responsible Party Name/Policy Holder of Insurance: _____

Responsible Party Date of Birth: _____

Responsible Party Social Security #: _____ - _____ - _____

May We Leave a Message For You Regarding Medical or Personal Information Relating to Your Care?

YES **or** **NO** (please circle)

Who is Your Primary Care Physician? _____

Primary Care Phone #: _____

Who Referred You to Our Office? _____

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize University Dermatology to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Worker's Compensation.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me, if it is with a company for which University Dermatology has a contract. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

SIGNATURE: _____ DATE: _____
Patient (over 18 years) or Responsible Party

**This information is being collected for informational purposes. This does not replace or change our obligations under state and federal law with regard to treatment and use and disclosure of healthcare information.