Welcome To Our Office!

Today's Date:

Name:_____
First Middle Last

Birth Date: _____Age: _____ SSN: _____ SEX: M F

Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____
Cell Phone: ( ) _____ Marital Status: S M D W
Work Phone: ( ) _____
Employer: _____Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

Primary Care Physician: _____
Referring Physician_____

Complete this section only if someone other than the patient is the insured.

Responsible Party: _____ Relationship to Patient: _____
Birth Date: _____ Age:_____ SSN: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____
Cell Phone: ( ) _____
Work Phone: ( ) _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

Name of Spouse: _____Birth Date: _____Age: _____
Cell Phone: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____
Occupation: _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____
Cell Phone: ( ) _____

(OVER PLEASE)

Insurance Information

Today's Date

Patient's Name: _____
First Middle Last

Primary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____Date of Birth: _____
Group Number: _____Policy ID Number: _____
Employer: _____
Social Security Number of the Insured: _____

Secondary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____Date of Birth: _____
Group Number: _____Policy ID Number: _____
Employer: _____
Social Security Number of the Insured: _____

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, copays, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit:___Cash ___Check ___Visa/MC/Discover

Signature of Patient /Responsible Party:_____ Date: _____

Signature of Patient/Responsible Party: _____Date: _____

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical and surgical benefits to Jennifer Alberts, MD.

Signed: _____ Date: _____
(Patient /responsible party)

Signed: _____Date: _____

List Physicians you give permission for Grand Island Dermatology to release your medical information to: _____

How did you learn about our practice? _____

Do we have your permission to?
Contact you or leave a message on your home or cell phone regarding your health care issues?

Yes No

Contact you or leave a message at your place of employment? Yes No