SAN ANTONIO SKIN AND CANCER CLINIC

PATIENT INFORMATION

Name (last) _____ (first) _____ (MI) ____ Age _____ Date of Birth _____

Address_____ Apt# _____City_____ St_____ Zip_____

Primary Phone _____ Home/Cell Secondary Phone _____ Home/Work/Cell

Employer: _____Occupation_____Phone # _____

Social Security # _____-_____-_____ Sex: M / F Marital Status: S M D W Spouse Name _____

Email Address: _____

Referring Physician _____Tel #_____

If patient is a minor: Father's name_____ Mother's name _____

In case of emergency, contact:

_____ Relation to patient _____ Home Phone _____ Cell Phone _____

PRIMARY INSURANCE

Ins Name _____ Policy ID _____Group # _____

Policyholder: _____DOB ___/___/_____SSN_____-_____-_____ Relation to patient _____

Address (if different from above) _____City _____ ST _____ Zip _____

Name of Employer _____ Employer Tel # _____ Occupation _____

SECONDARY INSURANCE (if applicable)

Secondary Ins Name_____ Policy ID _____Group # _____

Policyholder: _____DOB ___/___/_____SSN_____ Relation to patient _____

Address (if different from above) _____City _____ST _____Zip _____

Name of Employer _____ Employer Tel # _____ Occupation _____

AUTHORIZATION and ACKNOWLEDGEMENT

I/We hereby state that the above information is true and correct to the best of my/our knowledge. I/We authorize the above named practice to release any information acquired i the course of my treatment to my insurance company, employer, Physicians, institutions or third party payers, as required for certain claims filed.
I/We authorize direct payment to be made to the above named practice for any and all-medical or surgical services rendered. I/We understand if my insurance carrier does not cover any services or charges or my eligibility can not be verified, I/We are responsible for all charges incurred.

Signature of Patient/Parent/Guardian/Insured _____Date_____

ALLERGIES: (medications, rubber latex, anesthetics: _____

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