PATIENT INFORMATION

It is **Required** that form be completed annually in its entirety (Including Insurance and Credit Card/Health Savings information).

Legal Name ____________ | ___ | ____________ | ___ | ____________ Home Phone (_______)____________
(First) (M.I.) (Last) (Suffix) (Nickname) Work Phone (_______)____________
Date of Birth____/____/____ Soc. Sec. #________-____-________ Cell Phone (_______)____________
Address____________________________ **Circle one:** Single Married Wid Div
City______________ State________ Zip____________ Referring Physician (If Any)____________

Occupation____________________________ Employer____________________
Employer's Address____________________________ City____________ State____ Zip________

Patient's **Primary** Medical Insurance Company____________________________
Policy Holder____________________ Policy Holder's Relationship to Patient____________
Policy Holder's Date of Birth_____/_____/_____ Policy Holder's Address____________________
Policy Holder's Phone (_______)____________ ____________________

Patient's **Secondary** Medical Insurance Company____________________________
Policy Holder____________________ Policy Holder's Relationship to Patient____________
Policy Holder's Date of Birth_____/_____/_____ Policy Holder's Address____________________
Policy Holder's Phone (_______)____________ ____________________

Name of Spouse or Parent____________________ Phone (_______)____________
Address____________________________ Soc. Sec. #________-____-________
Occupation____________________________ Employer____________________
Employer's Address____________________________ Work Phone (_______)____________

Patient's next of kin to notify in case of emergency (**other than spouse**) Name ____________________
Phone (_______)____________

Medical Problem for which you see or have seen a Physician (other than for colds and flu)
____
____

Present Medications____
____

Allergic to any Medications? Yes / No (**circle one**) If yes, Name of Medications____________________
____

Past Surgeries____
____

I hereby authorize Hudson Dermatology, P.C. to furnish information to my insurance carrier(s) concerning treatment. I am responsible for any financial obligations for services for the above patient, including any amounts due after insurance benefits are received. If for any reason the account should become delinquent I agree to pay for all rebilling charges ($5), all collections costs and reasonable attorney's fees incurred, whether or not litigation is initiated. I further authorize Hudson Dermatology, P.C. to place charges on the credit card or health savings card I have provided. I understand that, once charges have been filed with my insurance(s) and explanation(s) of benefits have been issued, that any remaining amounts due which are patient/my responsibility (deductibles, co-pays, or non-covered services) will be placed on this credit card or health savings account. I further understand that Hudson Dermatology will be authorizing (not charging) up to $300 on the provided credit card or health savings account on the day services are provided.

Underline one of the following (Required): VISA MASTERCARD AM EXPRESS DISCOVER

LAST 4 DIGITS __ __ __ __ EXPIRES __ __/__ __

*****If you are providing a new card, give it to front desk staff so that additional information may be put into computer system.**

____________________ ____________________
Printed Name of Responsible Party **Printed Name of Patient**
(if different from responsible party)

____________________ ____________________ ____________
Signature of Responsible Party **Signature of Patient** **Date**
(if different from responsible party)

COPAYMENTS AND PREVIOUS ACCOUNT BALANCES ARE DUE AT THE TIME OF CHECKING OUT ON THE DAY THAT SERVICES ARE RENDERED