SUSONG DERMATOLOGY

PATIENT INFORMATION SHEET

Date: _____

PATIENT INFORMATION (Please Print)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SSN _____ MARITAL STATUS: S M W D

DATE OF BIRTH _____ AGE _____ SEX M F

HOME # _____ CELL # _____

WORK # _____ EXT. _____

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RESONSIBLE PARTY INFORMATION (If patient is a minor) (Please Print)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SSN _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____

HOME # _____ CELL # _____

WORK # _____ EXT. _____

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE # _____

LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ Declined to Specify

ETHNIC GROUP
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Other _____
- ☐ Declined to Specify

RACE
- ☐ White
- ☐ African American/Black
- ☐ Asian
- ☐ Other _____
- ☐ Declined to Specify

INSURANCE INFORMATION

PRIMARY INSURANCE _____

CARD HOLDER'S NAME _____

INSURED SS# _____ DATE OF BIRTH _____

GROUP # _____ POLICY # _____

EMPLOYER _____

SECONDARY INSURANCE _____

CARD HOLDER'S NAME _____

INSURED SS# _____ DATE OF BIRTH _____

GROUP # _____ POLICY # _____

EMPLOYER _____

Reason for your visit to our office today: _____

Name of the person/provider who referred you here: _____

Primary Care Physician: _____

I authorize the release of medical or other information about me to the listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Copays are due at time of service. All accounts should be paid within 90 (ninety) days of insurance being posted to prevent further action. I/we agree to pay any collection or attorney fees owed in addition to court costs if charges are not paid within the terms stated above and legal action is necessary to obtain collection.

I/we give permission for my/our minor child to receive medical attention.

I/we certify that I/we have read all of the above and the information given is true.

I understand that **missed appointments** without a compelling reason may be charged a no-show fee of $50 for an office visit and $100 for a surgical visit unless 24 hours' advance notice is given. Visit our website at www.susongderm.com for more information.

PATIENT/GUARANTOR SIGNATURE _____ DATE _____