DERMATOLOGY CENTER OF RICHMOND

(Please Print)

Today's date:	Primary care provider:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Email:	Birth Date: / /

Street address:	Social Security no.:	Phone no.:Home/Work/Cell(circle one) ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:

Referred to clinic by (please choose one):

Dr_____ Other_____

May we leave a detailed message?(circle one) Yes No

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Name of primary insurance:	Group no:

Subscriber name:	Birth date: / /	Policy no:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.: Group no:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Primary phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DCR or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*