PENINSULA DERMATOLOGIC SURGERY, INC.
PATIENT INFORMATION

FULL NAME: _____ DOB: _____ SEX: M F

SSN (Optional): _____ Email address: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Other SPOUSE/PARTNER NAME:

YOUR EMPLOYER:_____ OCCUPATION: _____ LENGTH OF TIME: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

GENERAL MEDICAL DOCTOR: Dr. _____

REFERRING PHYSICIAN: Dr. _____

INSURANCE

As a courtesy, PDS Inc. will bill participating insurance providers.

IF YOUR INSURANCE REQUIRES PRE-AUTHORIZATION PLEASE NOTIFIY US IMMEDIATELY

We participate with Medicare and many PPO plans. **We are not in contract with any HMO, *Multi-Plan* providers, Anthem Blue Cross Covered California or Blue Cross Affordable Care Compliance Plans. It is your responsibility to confirm with your insurance company that we are a contracted provider.** Please bring your card so we may copy it.

PRIMARY INSURANCE:_____ SUBSCRIBER NAME: _____
GROUP NUMBER: _____ ID#: _____
INSURANCE ADDRESS: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE: _____ SUBSCRIBER NAME: _____
GROUP NUMBER: _____ ID#: _____
INSURANCE ADDRESS: _____ EFFECTIVE DATE: _____

IF YOU ARE NOT THE PRIMARY SUBSCRIBER, PLEASE COMPLETE BELOW:
RELATIONSHIP TO THE SUBSCRIBER: _____ SUBSCRIBER NAME:_____ THEIR DOB: _____
INSURANCE ADDRESS: _____ EFFECTIVE DATE: _____

General Consent for Initial Patient Exam: I understand that I have come to **Peninsula Dermatologic Surgery, Inc.** for evaluation and treatment of skin disorder or condition. I consent to general physical examination and treatment. I understand that for medical records and educational purposes photos may be necessary.
Credit Policy: I understand that I am financially responsible for my account regardless of my insurance and for charges which are either for medical care not covered by my policy or a result of not following the required procedures of my health plan. All charges are due and payable at the time of service unless otherwise specified by an insurance company that is contracted with us.
Authorization and Assignment of Benefits: I authorize the release of any medical information necessary to process this claim and request payment of medical benefits be made directly to this physician unless payment is made in full at the time of service. There possibly will be a charge for re-processing a claim for insurance purposes. I also understand that it may be necessary for me to bill my own insurance.

SIGNATURE: _____ DATE: _____