ASHEBORO DERMATOLOGY & SKIN SURGERY CENTER

Date _____

Patient's Name _____
(First) (Name You Go By) (Middle/Maiden Initial) (Last)

Address _____ City/State/ZIP _____

Home Phone # _____ Age _____ Birthdate _____ Sex _____ Race _____

Cell # _____ SS # _____ Employed by _____

Employer's Address _____ Work Phone # _____

Please check at least one box below and answer rest of that section on the person you have named.

❑ Minor (under 18) — Parent/Guardian _____ SS # _____
**** Parent or Guardian that brings minor child into the office is responsible for payment.

❑ Single: Contact Person _____ Relationship _____ Cell # _____

❑ Married: Spouse _____ SS # _____ Cell # _____

❑ Widow(er): Contact Person _____ Relationship _____ Cell # _____

❑ Other: Contact Person _____ Relationship _____ Cell # _____

Address _____ City/State/ZIP _____ Phone # _____

Employer _____ Address _____

City/State/ZIP _____ Work Phone # _____

** SIGN AUTHORIZATION AT BOTTOM **

Insurance Company	Policyholder Name & Birthdate	SS # or Certificate #
_____	_____ _____ Month / Day / Year	_____
_____	_____ _____ Month / Day / Year	_____

Person responsible for payment _____ Phone # _____

Were you referred by a Doctor? Yes ❑ No ❑ If yes, what Doctor? _____

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

PATIENT VERIFICATION OF CORRECT INSURANCE

I have presented Asheboro Dermatology and Skin Surgery Center (ADSSC) with my CURRENT/CORRECT insurance card. If I or ADSSC find that I was covered by a different insurance on ANY date of service, ADSSC will file a claim, if new information is presented in a timely manner. However, I understand that I am responsible for medical services received and denied for late filing due to incorrect information provided.

Signature _____ Date _____

PATIENT ACKNOWLEDGMENT OF RECEIPT/REVIEW OF PRIVACY PRACTICES

I have had opportunity to review the Notice of Privacy Practices of Asheboro Dermatology and Skin Surgery Center and understand that I may have a copy if I choose.

Signature _____ Date _____