RAJAN DERMATOLOGY

Home #: _____

Cell #: _____

Email Address: _____

PATIENT INFORMATION

Name: _____ SS#: _____
Last Name First Name Initial

Address: _____ City: _____ State: _____ Zip code: _____

Sex: ☐ M ☐ F Age: _____ DOB: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Primary Care Physician: _____

In case of emergency who should be notified. _____ Phone #: _____

PRIMARY INSURANCE

Person Responsible for account: _____
Last Name First Name Initial

Relation To Patient: _____ DOB: _____ SS#: _____

Address (if different from patient's): _____ Phone #: _____

City: _____ State: _____ Zip code: _____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Insurance Company: _____ Phone #: _____

Group #: _____ Subscriber #: _____

Name of other dependents covered under this plan: _____

ADDITONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____ Relation to Patient _____ DOB: _____

Address (if different from patient's): _____ Phone #: _____

City: _____ State: _____ Zip code: _____

Subscriber Employed By: _____ Business Phone #: _____

Insurance Company: _____ Phone #: _____

Group #: _____ Subscriber #: _____

Name of other dependents covered under this plan: _____

ASSIGNMENT AND RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charged whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**