



Please write clearly...

Patient Name: \_\_\_\_\_ Name you are called by: \_\_\_\_\_  
                    First                    Middle                    Last

Address: \_\_\_\_\_  
                    Street/ Apt. #                    City                    State                    Zip

Phone: \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Male  Female  Single  Married  Other Primary Care Physician: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ SS# \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PLEASE PROVIDE CARDS TO SCAN INTO OUR SYSTEM.**

**Primary Insurance:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Self  Spouse  Father/guardian  Mother/ guardian SS# \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Self  Spouse  Father/guardian  Mother/ guardian SS# \_\_\_\_\_

**MEDICARE PATIENTS ONLY**

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or parent (if a minor)

I authorize payment of insurance benefits, otherwise payable to me, directly to Aspen Dermatology. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents. I authorize Aspen Dermatology to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that payment in full for charges is not made, I agree to pay for all costs of collection including a collection fee and court costs.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Parent