ALAMO DERMATOLOGY ASSOCIATES, P.A.
WELCOME TO OUR OFFICE

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL.

Patient Last Name	Patient First Name	MI	SS#	
Address		City	State	Zip
Birthdate	Sex ☐ Male ☐ Female			
Please check which number or enter an email address, you would like us to confirm your appointment with. ☐ Home Phone: ☐ Work: ☐ Cell:				
Email Address		Driver's License #		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed				
Referred By	Family Physician		Phone	
Emergency Contact	Relation to patient		Phone	

EMPLOYER INFORMATION (PLEASE PROVIDE THE POLICY HOLDER'S EMPLOYMENT INFORMATION)

Employer	Work Phone	Cell
Employer Address		Occupation

Insurance Information

PRIMARY Insurance Co.	Name of Insured	
Relationship of Patient to Insured	Insured Date of Birth	Insured SS#
SECONDARY Insurance Co.	Name of Insured	
Relationship of Patient to Insured	Insured Date of Birth	Insured SS#

PHARMACY NAME: _____ PHONE: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE.

Payment Policy: All professional services rendered are charged to the patient. The patient is responsible for any copayments, deductibles and other applicable fees determined by your insurance carrier at the time of each office visit. Please remember it is ultimately the patient's/guardian's responsibility to be aware of your benefits.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

THE UNDERSIGNED AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED FOR MYSELF OR DEPENDENTS AND AGREE THAT MY SIGNATURE BELOW AUTHORIZES CLAIMS SUBMITTED FOR SERVICES RENDERED. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY AND ASSIGN DIRECTLY TO ALAMO DERMATOLOGY ASSOCIATES, P.A. ALL REIMBURSMENT BENEFITS PAYABLE.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED SHOULD MY INSURANCE FAIL TO PAY OR IF THE INSURANCE DOES NOT PAY WITHIN 90 DAYS; THE BALANCE IS DUE FROM ME.

I HEREBY AUTHORIZE ALAMO DERMATOLOGY ASSOCIATES, P.A. TO RELEASE BY MAIL, TELEPHONE, FAX ANY MEDICAL OR INCIDENTAL INFORMATION THAT MY BE NECESSARY FOR EITHER MEDICAL CARE OR PROCESSING APPLICATIONS FOR FINANACIAL BENEFITS.

I CERTIFY THAT THE INFORMATION GIVEN BY ME IS CORRECT. I UNDERSTAND THAT ALL APPILICABLE FEES FOR SERVICES PROVIDED BY ALAMO DERMATOLOGY ASSOCIATES, P.A. ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

_____ _____

AUTHORIZED SIGNATURE OF PATIENT, INSURED AND OR GUARDIAN Date