Front Desk Check–in

initials ___________

Patient Information

Please Complete All Sections

Account # _________________

Office Location _____________
Today's Date _______________
□ New Patient
□ Name Change
□ Address Change
□ Insurance Change

Name (First, MI, Last)____Date of Birth _____/_____/_____Age:_____ Sex: M F

Mailing Address (street) ____Apt#_______________

City ____State _________________________Zip_____________

Home Phone (_____)________________Daytime Phone (_____)________________Mobile Phone(_____)_____________________

SS#____ Marital Status:□ Single □ Married □ Divorced □ Widowed □ Separated

Email Address _______________________________________Would you like to receive emails from West Dermatology for patient and practice communication only? Yes No ?

Employer ____ Phone Number (_____)______________________

Employer Address ____

Name of referring physician (Primary Care Physician) ______________________________ Phone Number(_____)_______________

Other family members that are patients ____

Parent, Spouse, or Responsible Party

Name (First, MI, Last)____Date of Birth _____/_____/_____Age:_____ Sex: M F

Mailing Address (street) ____Apt#_______________

City ____State _________________________Zip_____________

Alternate Address (optional) ____

Home Phone (_____)________________Daytime Phone (_____)________________SS#______________________________________

Employer ____ Phone Number (_____)______________________

Employer Address ____

Insurance Coverage-Primary

Name of Policy Holder (Insured) ____ Date of Birth _____/_____/_____

Insurance Comp. Name ______________________________________ Insurance Phone# (_____)____________________________

Co-pay $ _________________ Social Security # _______________________________

Address of Claim Center (street, city, state, zip)____

Policy # _______________________________________ Group Name or number#____

Policy Type: ☐PPO ☐EPO ☐POS ☐HMO If HMO, Name of Medical Group ____

Employer ____ Phone Number (_____)______________________

Employer Address ____

Patient's relationship to Insured: ☐Self ☐Spouse ☐Child ☐Step-child ☐Other _______________________________________

Insurance Coverage-Secondary

Name of Policy Holder (Insured) ____ Date of Birth _____/_____/_____

Insurance Comp. Name ______________________________________ Insurance Phone# (____)____________________________

Address of Claim Center (street, city, state, zip)____

Policy # _______________________Social Security #_____________________ Group Name or number _______________

Policy Type: ☐PPO ☐EPO ☐POS ☐HMO If HMO, Name of Medical Group ____

Employer ____ Phone Number (_____)______________________

Employer Address ____

Patient's relationship to Insured: ☐Self ☐Spouse ☐Child ☐Step-child ☐Other _______________________________________

Please turn form over and complete other side

Account # ________________

Patient Information

Continued

In case of emergency

Name of friend or relative not residing with you

____

Relationship to patient ______________________________ Address ____

Day phone# (_____)________________________________ Evening phone# (____)___________________________________

Pharmacy Information

Pharmacy Name____

Address____

Phone number# (____)______________________________ Fax number# (____) ______________________________________

How did you hear about West Dermatology?

☐Newspaper ☐Radio ☐Magazine ☐Physician ☐Family/Friend ☐Yellow Pages ☐TV ☐Direct Mail

☐Other____

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature: ____ Date _____/_____/_____

Payment Policy

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any **applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. Your signature below signifies your understanding and willingness to comply with these policies.

A $25.00 "No Show" fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment.

A fee will be charged for any returned checks.

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it, it may be necessary to reschedule your appointment.

I have read the Payment Policy and Insurance coverage described above. I understand and agree to all its provisions.

Patient Signature: ____ Date _____/_____/_____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov