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	Maiden
Address	City	State	Zip
Phone ( )	Work ( )	Cell ( )	
Birthdate / /	Sex : ☐ Male ☐ Female	SS#	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Driver's License#	
Referred By:	Family Physician:		
Emergency Contact:	Relation to patient:	Phone( )	
Friend or Relative not living with you:	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.

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AUTHORIZED SIGNATURE OF PATIENT, INSURED AND OR GUARDIAN DATE