

Welcome To Our Office

PLEASE PRINT and COMPLETE ALL PARTS

AURORA/MERIDIAN/PARKER SKIN CARE CENTER

Patient Account Number _____

Today's Date _____

PATIENT NAME: (This section refers to PATIENT ONLY)

Last _____ First _____ Middle _____

Address _____ Apt. No. _____ City _____ State _____ Zip _____

Home Phone _____ Voice Mail/Alt. Phone _____ Employer _____

Date of Birth _____ Age _____ Marital Status _____ Sex _____ Social Security # _____

Primary Care Doctor: _____

Address: _____ Phone: _____

BILLING NAME AND ADDRESS: (If not the same as above)

Name _____ Relationship to Patient: Self Spouse Parent Other

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance _____ Secondary Insurance _____

Mailing Address _____ Mailing Address _____

City, State, Zip _____ City, State, Zip _____

Phone: Area () _____ Phone: Area () _____

Primary Insured Person _____ Primary Insured Person _____

Employer _____ Employer _____

ID/Policy # _____ Suffix # _____ ID/Policy # _____ Suffix # _____

Effective Date _____ Effective Date _____

Group # _____ Group # _____

Social Security # _____ Social Security # _____

EMERGENCY CONTACT:

Name _____ Home Phone _____

Address _____ Work Phone _____

I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I also hereby apply for and voluntary consent to examination and treatment performed by the medical staff of Aurora/Parker Skin Care Center.

I hereby give permission for Aurora/Parker Skin Care Center to leave a message at my home phone number with regards to my personal medical care, including lab results, and billing questions.

Signature: _____
(Patient or Guardian if Patient is a Minor)

Date: _____