Patient Information Form

Patient Name:_____ Marital Status:_____
Last first m.i.

Home Address:_____

_____
city St zip

Home Phone: (_____)_____Work: (____)_____ Cell: (_____)_____

Social Security #:_____ Birthdate:_____ Age:_____

Driver's License: _____ State:____ E-mail: _____

Occupation: _____ Employer:_____

Emergency contact: _____
Name relationship phone

Name of Spouse/Parent: _____ Social Security # _____

Responsible Party ( )self ( )other: _____ Relationship to Patient: _____

Primary Insurance: _____Policy #: _____Group #_____

Insurance Address:_____

Policy Holder's Name: _____ Birthdate of Policy Holder: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to be sent to Coastline Dermatology Laser and Medical Center Inc, Margaret M. Shannon MD, INC. I understand and agree that, *regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered at this office*. It is my responsibility to know what my insurance may or may not cover, and to update any changes that may have occurred. All procedures deemed cosmetic must be paid for at the time of my visit. Same day cancellation will result in a fee based on what your appointment was for. I have read all the information on this form and have completed the above. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my insurance status, or any changes to the above information. I authorize Coastline Dermatology to bill my insurance.

Signature: _____ Date:_____

***How did you hear about us*? _____**