Chart ID: _____

DERMATOLOGY & SKIN CANCER CENTER
OF NEW MEXICO

Patient Information

Mr. Mrs. Ms. Miss _____

Address: _____

City: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____ Sex: M F

SSN: _____ Single Married Widowed

Emergency contact: _____ Ph# _____

Primary Care Provider : _____ Ph#_____

Referring Provider: _____ Ph# _____

Person Financially Responsible (If other than the patient)

Mr. Mrs. Ms. Miss _____

Address: _____

City: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____ Sex: M F

SSN: _____ Single Married Widowed

Relationship to Patient: _____

Primary Insurance Information:

Insurance Company: _____

Policyholder Name: _____ SSN:_____

Date of Birth: _____Relationship: _____

Employer Name: _____

Secondary Insurance Information:

Insurance Company: _____

Policyholder Name: _____ SSN:_____

Date of Birth: _____Relationship: _____

Employer Name: _____

I hereby authorize Dermatology & Skin Cancer Center of NM, PC to furnish information to insurance carriers concerning my medical condition and treatment and I hereby authorize payment of medical benefits to Dermatology & Skin Cancer Center of NM, PC for services provided. Co-payments for patients are due at the time of service. Please be aware that ultimately all fees are the responsibility of the responsible party, regardless of the insurance coverage. It is customary to pay for medical services when rendered, unless arrangements have been made in advance. My signature below affirms that I have read and understand this agreement.

Signature: _____Date: _____

I have received a copy of the NOTICE OF PRIVACY PRACTICES form.

Signature: _____Date: _____