DERMATOLOGY AND SKIN CANCER CENTER OF NEW MEXICO

Patient Information	**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 Email Address:_____ **Emergency contact: _____Ph#_____** Primary Care Provider : _____ Ph#_____ Referring Provider: _____Ph# _____	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: _____