GREEN | Dermatology & Cosmetic Center

Jason Green, DO, FAOCD, FAAD

PATIENT INFORMATION

Date: ______________________ Referred By: ______________________________

Male/Female ___________ Married/Single/Divorced/Widowed: ____________________

Patient Name: ____

Street Address: ____

City / State / Zip Code: ____

Phone Number: ____________________ Alternate (cell) Number: __________________

Date of Birth: ___________________ Drives License #: _________________________

Social Security #: ____________________ Email: _____________________________

Primary Care Physician: ____

Phone #: ____________________ City, State: ________________________________

If minor, name of parents(s) / guardian:

_____________________________________ Phone Number: __________________

Emergency Contact Name: ____

Phone Number: ______________________ Relationship: _______________________

Responsible Party:

Name: __________________________________ Relationship: __________________

DOB: ________________________ Social Security #: _________________________

Address: ____

City: __________________________________ State: _______ Zip Code: _________

Phone #: ___________________________ Alternate #: ________________________

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INSURANCE INFORMATION

Insurance Company: ______________________________ ID#:

Group #: ____________________ Insurance Phone Number: ___________________________

Subscriber Name: _________________________________DOB: _______________________

Subscriber Relationship To Patient: ____

DISCLOSURE STATEMENT

As a courtesy to you, we will file to your insurance company for services our medical providers rendered today. Once payment is received, we will adjust certain balances according to our contracts with your insurance carrier. If we do not have a contract with your insurance carrier, you will be responsible for payment at time of service.

I have spoken with a representative of Green Dermatology & Cosmetic Center and understand fully that I am responsible for all amounts not covered by insurance. I also understand that, in the event my insurance carrier does not pay, I am responsible for all additional charges incurred by Green Dermatology & Cosmetic Center or its agent to collect any debt.

Patient/Guardian Signature: _______________________________________Date:___________

Witness Signature: ____Date:__________

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