WELCOME TO
LAPLACE DERMATOLOGY CLINIC

PATIENT NAME: _____ **DATE:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

E-MAIL ADDRESS: _____

HOME PHONE: (____) _____ **WORK: (____)** _____ **CELL: (____)** _____

SOCIAL SECURITY #: _____/_____/_____ **SEX:** MALE ☐ FEMALE ☐

DATE OF BIRTH: _____ /_____ /_____ **AGE:** _____ **MARITAL STATUS:** _____

PATIENT EMPLOYER: _____ **OCCUPATION:** _____

INSURANCE COMPANY NAME: _____

ARE YOU INSURED UNDER SOMEONE OTHER THAN YOURSELF? YES ☐ NO ☐ _____

NAME OF CARDHOLDER/INSURED SUBSCRIBER: _____

DATE OF BIRTH: _____ /____ /_____ **RELATIONSHIP:** _____

PARENT'S EMPLOYER & PHONE NUMBER (IF PATIENT IS A MINOR):

_____ **Phone: (____)** _____

EMERGENCY CONTACT: _____ **Phone: (____)** _____

REFERRING PHYSICIAN NAME: _____ **Phone: (____)** _____

I authorize release of medical information necessary to process claims and authorize payment of benefits to Dr. Jack P. Murphy / LaPlace Dermatology. I am responsible for co-payments, deductibles, and co-insurance at the time of my visit. I understand even though LaPlace Dermatology is filing my insurance for me, I am ultimately the person responsible for any charges that occur at the time of my visits. I will be responsible for any and all charges that my insurance company denies or will not pay for. This includes any cosmetic services or elective procedures chosen by you or that insurance considers cosmetic or investigational. All treatments offered at LaPlace Dermatology are approved by the AMA and Centers for Medicare and Medicaid Services.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____

DATE: _____