

Pt. Acct. # _____
F.D. Initial _____

CENTRAL OHIO SKIN AND CANCER, INC.

Patient Information (Please Print Clearly)

Name _____ Employer _____ Occupation _____
Last First MI Address _____
City _____ State _____ Zip Code _____ Phone # () _____
Phone # () _____ Family Doctor _____
SSN _____ M _____ F _____ Phone # () _____
DOB _____ Age _____ Marital Status M S W D Referring Doctor _____
Spouse's Name _____ Phone # () _____
Family member previously seen in our office _____

Emergency Contact (Nearest friend or relative not residing with patient)

Name _____
Address _____
Phone # () _____

Guarantor Information (Responsible party i.e. parent or legal guardian)

Name _____ Employer _____
Relationship _____ Address _____
Address (if different) _____ Phone # () _____
City _____ State _____ Zip Code _____
Phone # _____

Primary Insurance Information

Secondary Insurance Information

Insurance Comp. _____ Insurance Comp. _____
Policy Holder _____ Policy Holder _____
Relationship _____ Relationship _____
SSN _____ DOB _____ SSN _____ DOB _____
Employer Name & Phone # _____ Employer Name & Phone # _____
ID/Subscriber # _____ ID/Subscriber # _____
Group # _____ Group # _____
Copay _____ Copay _____

The undersigned hereby authorizes treatment of the above named patient. I/we agree to promptly pay all charges for the patient, at the time of service unless other arrangements have been made with the billing office. The undersigned hereby authorizes release of any information pertaining to a claim filed with his or her insurance company. Central Ohio Skin & Cancer, Inc. is not responsible for procedures not covered by your insurance company. We will provide you with a statement. You are responsible for the bill.

Signature _____ Date _____

Pt reviewed _____ Date _____

Pt reviewed _____ Date _____

Pt reviewed _____ Date _____

Pt reviewed _____ Date _____