PLEASE CHECK ONE
☐ Gary R. Carlson, M.D.
☐ Randolph S. Capri, M.D.
☐ Michael R. Bastien, M.D.
☐ Thomas J. Kim, M.D.
☐ Holly L. Rausch, M.D.

DERMATOLOGY ASSOCIATES OF WESTLAKE VILLAGE
PATIENT INFORMATION FORM

Today's Date _____

Patient's Name _____
Last First Initial

☐Male ☐Female Age _____ DOB: / / / Marital Status ☐ S ☐ M ☐ W ☐ DIV

Social Security No. _____ Driver's Lic. # _____

Cell Phone _____ Home Phone _____

Address _____ City & State _____ Zip _____

Employers Name _____ Occupation _____

Employer's Address _____ City & State _____ Zip _____ Phone _____

Spouse or
Parent Name _____ Occupation _____

Spouse or
Parent Address _____ City & State _____ Zip _____ Phone _____

Spouse or
Parent Employers Name _____

Adress _____ City & State _____ Zip _____ Phone _____

Emergency Contact _____ Phone _____

Address _____ City & State _____ Zip _____

Who Referred you _____ Email _____

Please complete section below if patient is a minor

Mr.
Mrs.
Ms. _____
NAME STREET ADDRESS(NOT P.O BOX) CITY STATE ZIP PHONE

_____
EMPLOYER STREET ADDRESS CITY STATE ZIP PHONE

Social Security No. _____ Driver's Lic. # _____

INSURANCE INFORMATION: Indicate which insurance is primary (1) and secondary(2)

(1) NAME OF INSURANCE COMPANY SUBSCRIBER(POLICY HOLDER) SUBSCRIBER (DATE OF BIRTH)

(2) NAME OF INSURANCE COMPANY SUBSCRIBER(POLICY HOLDER) SUBSCRIBER (DATE OF BIRTH)

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to DERMATOLOGY ASSOCIATES for any services furnished to me by the physician. I undestand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE WILL BE SUBJECT TO A 1.5% FINANCE CHARGE

Date _____ Signed _____

MEDICARE SIGNATURE ON FILE: (SEE REVERSE)

"SIGNATURE ON FILE" REQUIREMENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to DERMATOLOGY ASSOC for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to the Health Care Financing Administration and its' agents any information needed to determine these benefits of the l payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the or the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determinatio Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncover Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Name of Beneficiary _____ HIC Number _____

MEDICARE PATIENTS

Are you currently employed ? Y N

If not employed, date of retirement _____

Is your spouse currently employed? Y N

Do you have group health plan coverage
based on your own, or a spouse's current employment? Y N

Does the employer that sponsors your Group Health
plan employ 20 or more employees? Y N

Does the employer that sponsors you Group Health
plan employ 100 or more employees? Y N

Name and address of Group Health Plan

_____

_____

_____

_____

Policy ID Number _____

Group ID Number _____

Name of Policyholder _____

Relationship to Patient _____

Do you have a third insurance? Y N

Name and address of third insurance

_____

_____

_____

Policy ID Number _____

Group ID Number