Medical Dermatology Associates of Chicago

Patient Information

First name: _____ Last name: _____ Date of Birth: _____

Address: _____ Unit: _____ City: _____ Zip Code: _____

E-mail: _____ Social Security #: _____

Primary phone (cell) #: _____ Secondary phone (other) #: _____

Gender: _____

Partnership status: _____ Occupation: _____

Primary Care Physician: _____ Phone number: _____

Referring Physician (if different): _____ Phone number: _____

Have you seen one of our doctors at a previous location, if so who? _____

Emergency contact: _____ Relationship: _____ Phone #: _____

Pharmacy Information

Name of pharmacy: _____ Street Address: _____
(cross streets)

City: _____ Zip code: _____ Phone number: _____

Mail order pharmacy (if applicable): _____

Insurance Information

Policy Holder Name: _____ Relationship to Patient: _____

Phone #: _____

Policy Holder Date of Birth: _____ Policy Holder Gender: _____

Assignment and Release

I hereby authorize the assignment of benefits (payments) directly to Medical Dermatology Associates for all insurance claims related to services rendered. I agree to pay any and all charges that exceed or are not covered by my insurance. I understand that co-pays, deductibles and charges for non-covered services are due at the time of service:

Signature of responsible party: _____ Date: _____

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I authorize the use of this signature on all insurance submissions:

Signature of responsible party: _____ Date: _____

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