PRESTON

DERMATOLOGY + SKIN SURGERY

PATIENT INFORMATION (Please fill out all requested information)

Today's Date: ____________

Name (First) ____________ (Middle) ____________ (Last) ____________

SS# ____________ Date of Birth ____________ Gender Male ____ Female ____

Street Address ____________

City ____________ State ____________ Zip ____________

Home Phone # ____________ Cell # ____________ Primary #, please circle: Home Cell

Referring Physician ____________ Primary Physician ____________

Email Address ____________ Marital Status ____________

☐ Please add my email (above) to the Preston email list for occasional newsletters featuring specials and events.
Use different email address for newsletter: ____________

Responsible Party (*If Patient is a Minor*) ____________ DOB ____________ SSN ____________

Address (*if different*) ____________ Relationship ____________

EMERGENCY CONTACT ____________ Phone # ____________ Relationship ____________

Primary Insurance

Insurance Company Name ____________ Policy Holder Name ____________

Policy Holder Date of Birth ____________ Relationship ____________

Secondary Insurance

Insurance Company Name ____________ Policy Holder Name ____________

Policy Holder Date of Birth ____________ Relationship ____________

AUTHORIZATIONS: I understand my services will be provided by Preston Dermatology, PA and that payment for services provided by Preston Dermatology PA will be my responsibility. My insurance carrier will be billed for these services as a courtesy and my uncovered charges, deductibles, or co-pays will be my responsibility. I hereby assign all medical benefits, if any, payable directly to this medical practice. I authorize the release of all information necessary to secure my benefits. I authorize Preston Dermatology, PA to submit claims to my insurance carrier in order to obtain payment for professional services rendered. In addition, my signature below constitutes my consent for treatment.

Preston Dermatology, PA uses outside vendors for completing testing services. I understand that the minimum necessary demographic, insurance, and medical information will be provided to the vendor to complete the testing. The outside vendor will bill me or my insurance company for the services they provide. I will be responsible for any and all charges, co-pays, and/or deductibles related to the testing services that are provided.

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, court costs, and all other costs related to the collection of this debt.

Signature ____________ Date ____________ Relationship (if minor) ____________