

PATIENT INFORMATION FORM

Patient's Name _____
 First Name Initial Last Name

Date of Birth (DOB): _____ Sex ___ M ___ F Social Security # _____

Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Email _____

Employer: _____ Occupation: _____

Marital Status: _____ Name of Spouse: _____

Subscriber Name on Insurance: _____ DOB: _____

Name of Parents (if a minor): _____

Address if Different from Patient: _____

Person Responsible for Payment: _____

Employer: _____ Address: _____

Person to Contact in Case of Emergency: _____

Telephone: _____

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Do you have Tuberculosis (TB)? ___ Yes ___ No

Is there a specific laboratory your insurance requires to be used? ___ Yes ___ No

If yes, which Laboratory? _____

Does your insurance require a predetermination for foot care? ___ Yes ___ No

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INSURANCE INFORMATION

Insurance Company: _____

Address: _____ City: _____ State: ___ Zip: _____

Subscriber Name: _____ DOB: _____

Contract # _____ Group # _____

Service Code and/or Plan Code: _____

Does this plan cover all family members? ___ Yes ___ No

<p>LifeTime Dermatology 230 W. Maple Rd., Suite 200 Troy, Mi 48084</p>	
<p>I authorize the release of any medical information necessary to process my insurance claim and I authorize payment of medical benefits to be made to the provider listed above for the services rendered.</p>	
<p>_____</p> <p>Date</p>	<p>_____</p> <p>Signature of Patient or Parent if patient is a minor</p>