Piedmont Cosmetic Surgery and Dermatology Center, P.A.

Name:____ ( ) Jr. ( ) Sr.
First Middle Last Preferred Name

Mailing Address:____
Street City State Zip

Home Phone:( )________________ Work Phone:( )________________ Cell Phone: ( )________________

Date of Birth:_____/_____/_____ Sex: M / F Social Security#:__________________ Marital Status:_______

Employer:____ Email Address:____________________________________

May we:

Leave a message on the answering machine at home? ( ) Yes ( ) No

Leave a message at your place of employment? ( ) Yes ( ) No

Discuss your medical condition with any member of your household? ( ) Yes ( ) No

If yes, Whom?__________________ What relation is this person to you?____________________

Responsible Party of Patient: (this information is required if patient is a minor)

Name:____ Relationship to Patient:______________
First Middle Last

Address (if different from above):____

Home Phone:( )_________________ Work Phone:( )__________________

Date of Birth:_______/_______/______ Social Security #:____

Insurance Information:

1) **Primary Carrier:**____
Policy Holder:____
Policy Holder's Date of Birth:_____________ Social Security #:________________________

2) **Secondary Carrier:**____
Policy Holder:____
Policy Holder's Date of Birth:_____________ Social Security #:________________________

3) **Additional Insurance:**____
Policy Holder:____
Policy Holder's Date of Birth:_____________ Social Security #:________________________

We will file your insurance, as a courtesy to you, for all charges. It is our policy to allow 30 days for insurance settlement and while we will help with any problems that may arise, you are ultimately responsible for charges. You are responsible for any required co-pay, deductible, and unpaid balance.
If you are a self-pay patient, you are responsible for payment for your office visit upon check in. If there are additional charges beyond the initial office visit, you will be required to pay 75% of that additional charge at check out.

____
Signature of Patient or Responsible Party **Date**

____
Signature of Witness **Date**