Dermatology Consultants of Marin, Inc.

5000 Civic Center Drive
San Rafael, CA 94903
(415)499-0100 Phone
(415)499-0290 Fax

Patient Information

Date _____

First Middle Last

Print Name _____ _____ _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work phone** _____

Marital Status:

Birth Date _____ **Sex**: Male Female Married ☐ Single ☐ Widowed ☐ Divorced ☐

Social Security No _____ **Email Address** _____

Name of Spouse/Parent _____ **Phone** _____

Emergency Contact _____ **Relation** _____ **Phone** _____

Primary Care Doctor _____ **Employer** _____

Insurance Carrier_____ **Subscribers Name & D.O.B**_____

Do we have your authorization to leave a private message at your preferred number listed above? Yes ☐ No ☐

Do we have your authorization to access your prescriptions from your pharmacy? Yes ☐ No ☐

I hereby authorize the processing of the **medical insurance** either be made by electronic or by manual method by **Dermatology Consultants of Marin, Inc.** My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer (listed above on this form) to pay Dermatology Consultants of Marin, Inc. I further authorize assignee to release all medical and/or insurance claim information necessary to secure payment(s). I recognize my financial obligations of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing.

Patient Signature: _____ Date: _____

I request that payment of authorization **Medicare** benefits be made on my behalf to **Dermatology Consultants of Marin, Inc.** for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature below requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 or the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the change determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date: _____