



# Gardens Dermatology

11030 RCA Center Drive  
Palm Beach Gardens, FL 33410  
561-776-7041 (phone)  
561-776-7043 (fax)



Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Patient Information

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Sex: \_\_\_M\_\_\_F  
                    Last                    First                    M.I.

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Single:\_\_\_\_ Married:\_\_\_\_ Widowed:\_\_\_\_ Divorced:\_\_\_\_ Separated:\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Insurance Information

Patient is responsible for providing correct and up to date insurance information. Correct insurance card must be presented for insurance filing purposes or claim will be considered self-pay. Failure to do so will result in patient being responsible for charges.

Primary Insured: \_\_\_\_\_  
                                    Last                                    First                                    M.I.

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Sex: \_\_\_M\_\_\_F

Primary Insurance Co: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Co-pay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Co-insurance: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Co-pay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Co-insurance: \_\_\_\_\_

## Assignment and Release

I, the undersigned, certify that I (or my dependent) have coverage with the insurance company with whom I have provided information and presented my insurance card. I assign directly to the providers at Gardens Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure all payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that any co-payments, co-insurance or deductibles that may apply to my insurance are my responsibility and payment is to be made at the time of service.

Responsible Party Signature: \_\_\_\_\_ Relation to Pt. \_\_\_\_\_ Date: \_\_\_\_\_