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: _____