Heidi H. Cole, M.D.

Medical, Surgical, and Cosmetic Dermatology

PATIENT INFORMATION

Patient's Name:_____ Birth Date:_____ M/F

Home Address:_____

City/State:_____ Zip:_____

Daytime Phone Number:_____ Evening Phone Number:_____

Cell Phone Number:_____

Marital Status: S M W D Spouse's name (if married) or Parent's name (if under 18)_____

Employer's Name:_____ Phone:_____

Spouse's Employer:_____ Phone:_____

Person to Contact for Emergency:_____ Phone:_____

Name of Policyholder:_____ Date of Birth:_____

Is this: ☐ Yourself ☐ Spouse ☐ Parent ☐ Other (Explain) _____

Name of Insurance Company:_____

Policy Number:_____ Group Number:_____

If you have any secondary or supplemental insurance, please provide the name & policy number:_____

_____

Person Responsible for Bill:_____

Address:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I have read all information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature:_____ Date:_____

Parent's (if minor):_____ Date:_____

ASSIGNMENT OF BENEFITS

I request that payment of benefits be made either to me or on my behalf to Dr. Heidi Cole, Dermatology, for services furnished me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:_____ Date:_____