BENJAMIN RAAB, M.D. ● Dermatology & Cosmetic Skin Surgery

PATIENT INFORMATION FORM

Please Print

PATIENT INFORMATION			
Patient's Last Name:	First:	Middle:	Date:
Street Address:			
City:	State:		Zip Code:
Date of Birth:	Age:		Gender:
Social Security Number:	E-Mail Address:		
Home Phone:	Work Phone:		Cell Phone:
May we contact you at above numbers?			
Marital Status:	Spouse's Name:		Work Phone:
Emergency Contact:			
Relationship:	Phone Number:		
How did you hear about us?			
Staff may discuss my medical treatment with the following person(s):			

PRIMARY HEALTH INSURANCE INFORMATION		
Subscriber's Name:		Gender:
Date of Birth:	Relationship to Patient:	
Social Security Number:		
Street Address:		
City:	State:	Zip Code:
Home Phone Number:	Work Phone Number:	
Employer:	Employer Address:	

Your records are always protected, private, and confidential and are used only for payment, treatment, or healthcare operations in compliance with the Health Insurance Portability and Accountability Act "HIPAA" of 1996 (policy available upon request). Your signature acknowledges your understanding and compliance with the above and allows authorization to release medical information for medical payment and treatment purposes.

Signature of Patient, Parent, or Legal Guardian: *Date:*

Thank you for choosing us as your healthcare provider. A clear understanding of our financial policy is important in order to establish optimal professional relations with our patient and avoid misunderstandings and confusion. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check, or major credit card. In the event of PPO/HMO/Medicare contracts, our office will file with the appropriate insurance carrier. (See Form 2)

Should it be necessary for us to utilize the services of an outside collection agency in order to collect the amount which is due and owed by you, you will be held responsible for any and all collection agency and/or attorney fees. Information that is helpful or necessary for collection purposes will be forwarded to our professional collection agency.

Your signature below signifies your understanding and willingness to comply with this policy and authorization to perform medical treatment, therapy, and medication that may be indicated.

Signature of Patient, Parent, or Legal Guardian: *Date:*