Welcome to Our Office

Patient Information

Patient Name _____ (First) _____ (Middle) _____ (Last)

Today's Date _____ Date of Birth _____ Gender _____ SS# _____

Patient Address _____

City _____

State _____ Zip Code _____

Phone ( ) _____

E-Mail Address _____

Employer Name _____

Address _____

_____

Phone ( ) _____

Financially responsible party (Minors Only)

Name _____

Address _____

_____

Phone ( ) _____ DOB: _____

Responsible Party SS# _____

Referring Doctor or Primary Care Doctor (**Required**)

Name _____

Address _____

_____

Phone ( ) _____

Type of Doctor _____

Race		Hispanic/Latino	Language
❑White/Caucasian	❑American Indian or Native Alaskan	❑Yes ❑No	❑English
❑Asian	❑Native Hawaiian/Pacific Islander		❑Spanish
❑Black/African American	❑Other _____		❑Other _____

Insurance Information

Is this Visit the result of an auto or work related accident? Auto: ❑Yes ❑No Work: ❑Yes ❑No

Primary Insurance (to be billed first)

Name of Insurance Company _____

Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Patient _____ SS# _____

Secondary Insurance

Name of Insurance Company _____

Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Patient _____ SS# _____

Emergency Contact

Name _____ Phone _____ Relationship _____

I hereby authorize Paragon Health DBA Southwest Michigan Dermatology to examine and treat my child, or me and to perform such diagnostic test and/or x-rays as may be necessary for the duration of treatment for this injury/illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy be paid directly to Southwest Michigan Dermatology. I understand that this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders and/or HIV serostatus. I understand that I am responsible for the fees for all services rendered (and equipment/supplies provided) to my child or me. I guarantee payment of the portion of my account for which I am responsible at the time of service or within the pre-arranged time frame agreed upon by the business office. I agree that, in the event I default and do not pay my balance, reasonable costs of collection, and/or reasonable attorney fees may be added to the amount due on the account and I agree to be financially responsible for those additional charges.

_____ _____

Signature of Patient/Responsible Party **Date**