

Front Desk Check-in
initials _____



LAS VEGAS
**SKIN &
CANCER
CLINICS**

Patient Information
Please Complete All Sections

Account # _____

Office Location _____
Today's Date _____
 New Patient
 Name Change
 Address Change
 Insurance Change

Name (First, MI, Last) _____ Date of Birth ____/____/____ Age: ____ Sex: M F
Mailing Address (street) _____ Apt# _____
City _____ State _____ Zip _____
Home Phone (____) _____ Daytime Phone (____) _____ Mobile Phone(____) _____
SS# _____ Marital Status: Single Married Divorced Widowed Separated
Email Address _____ Would you like to receive emails from West Dermatology for patient
and practice communication only? Yes No
Employer _____ Phone Number (____) _____
Employer Address _____
Name of referring physician (Primary Care Physician) _____ Phone Number(____) _____
Other family members that are patients _____

Parent, Spouse, or Responsible Party

Name (First, MI, Last) _____ Date of Birth ____/____/____ Age: ____ Sex: M F
Mailing Address (street) _____ Apt# _____
City _____ State _____ Zip _____
Alternate Address (optional) _____
Home Phone (____) _____ Daytime Phone (____) _____ SS# _____
Employer _____ Phone Number (____) _____
Employer Address _____

Insurance Coverage-Primary

Name of Policy Holder (Insured) _____ Date of Birth ____/____/____
Insurance Comp. Name _____ Insurance Phone# (____) _____
Co-pay \$ _____ Social Security # _____
Address of Claim Center (street, city, state, zip) _____
Policy # _____ Group Name or number# _____
Policy Type: PPO EPO POS HMO If HMO, Name of Medical Group _____
Employer _____ Phone Number (____) _____
Employer Address _____
Patient's relationship to Insured: Self Spouse Child Step-child Other _____

Insurance Coverage-Secondary

Name of Policy Holder (Insured) _____ Date of Birth ____/____/____
Insurance Comp. Name _____ Insurance Phone# (____) _____
Address of Claim Center (street, city, state, zip) _____
Policy # _____ Social Security # _____ Group Name or number _____
Policy Type: PPO EPO POS HMO If HMO, Name of Medical Group _____
Employer _____ Phone Number (____) _____
Employer Address _____
Patient's relationship to Insured: Self Spouse Child Step-child Other _____

Please turn form over and complete other side



Account # _____

Patient Information
Continued

In case of emergency

Name of friend or relative not residing with you

Relationship to patient _____ Address _____
Day phone# (____) _____ Evening phone#
(____) _____

Pharmacy Information

Pharmacy Name _____
Address _____
Phone number# (____) _____ Fax number# (____)

How did you hear about West Dermatology?

Newspaper Radio Magazine Physician Family/Friend Yellow Pages TV Direct Mail
Other _____

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature: _____ Date ____/____/____

Payment Policy

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any **applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient’s financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. Your signature below signifies your understanding and willingness to comply with these policies.

A \$25.00 “No Show” fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment.

A fee will be charged for any returned checks.

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it, it may be necessary to reschedule your appointment.

I have read the Payment Policy and Insurance coverage described above. I understand and agree to all its provisions.

Patient Signature: _____ Date ____/____/____